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PASSIM

WE must leave the final summing-up of the past year to the historian, the Gibbon of the future. Let him decide to whom honours are due. He must reveal the perplexities and mysteries to us, for we are too close to the battle-front, blinded by the smoke and fumes, to place the right values on each event and action.

Still, we may allow ourselves the right to feel satisfied that the final round of this stupidity of war is beginning—in our favour, thanks to the magnificent feats of arms of our Allies, particularly our Russian comrades, for comrades they must and shall be if the decisions at Teheran are not to be an idle mockery.

We have made a painful journey down from the mountain-tops of 1940. We weathered the storms and torrents of 1941 with blind courage and determination. Before us now lies the last raging torrent we must cross before we come to the valley of peace. Is it a fertile valley flowing with milk and honey or is it strewn with the bones of men who have lost hope, with the boulders of cynicism and apathy? The soil is virgin yet; it lies safe in the womb of the future. What are we to make of it?

What are the tools we shall need for the cultivation of that soil? We shall need a universal faith in the future of that valley, that it is really worth all the agony of blood and tears that will be shed. A combine harvester is not the first thing that a modern farmer buys. Some years ago John Steinbeck wrote a novel, "The Grapes of Wrath," in which he drew a picture of an American family, uprooted from the barren soil of the Mid-West, and how it trekked to California to find the Happy Valley. There lay faith in the future. There lay courage.

What happend when that family reached California? It was greeted with bitter disappointment, but yet its spirit remained firm. Supposing we reach the Happy Valley, what will become of us? That depends partly on our attitude towards our fellow-beings, and therein lies the second implement we shall need for that agricultural experiment we spoke of. Understanding breeds tolerance, and refusal to acknowledge facts and their implications leads us aside from the paths of understanding. We may not love our neighbour, but it helps a great deal if we can understand him. The second commandment is harder for most people to obey than the first, "God" being widely interpreted. The inevitable result is that we must first have a philosophy to replace that vacuum of the post-Great War world, that "long week-end" of irresponsibility; and that, secondly, we build our post-war frontiers of tissue-paper.

Why, you may well ask, should all this idealistic bunkum appear in a hospital gazette? Because it may possibly be read by some of the present generation of students who have had to remain behind, untouched, perhaps, by the fierce reaction and hatred against the evils of war which our fighting brothers have seen and have had branded in them. It will fall to us to be in the vanguard of the parties which will raise the dignity and hope of a shattered Europe. Shall the blind lead the blind? We dare not let them.

We are being trained here at Guy's in the arts of healing the sick both in body and mind, but are we training ourselves in the arts of citizenship and democratic responsibility? It lies wholly within our power to do so. This is what Plato thought of the matter: "Those who have no natural aptitude for justice and other noble ideals, and no affinity with them, will never learn the full truth about good and evil, however good their intelligence and memory may be in other fields."

Let us, therefore, in 1944, a year which will mean so much to us both in freedom and suffering, cultivate what "natural aptitude for justice and other ideals" we may have.

Influenza Sincera

By H. ST. H. VERTUE.

INASMUCH as there are many illnesses passing under the name "influenza," all closely allied but not the same, it seemed good to me to append to what I am going to describe the epithet "sincera," meaning "whole," "real." "genuine," to be distinguished from the "fucata" (dyed or rouged) and the "simulatu" (counterfeit). Even as I write there is an epidemic of a mild illness which may be due to a strain of the influenzal virus sure enough, but it is different from that dangerous disease which he who has once seen it will not fail to recognise again. I mean the sort of influenza that visited Europe like a plague in 1918. I have just seen this sort again last October in a local epidemic that broke out in Orpington, chiefly among the nursing staff, and, to a small extent, among the medical, dispensing and domestic staff. The outbreak in 1918 began in a comparatively innocuous form in the summer; then came a second wave in the autumn and winter, which was very fatal. The difference between the two was due to the fact that in the latter there was broncho-pneumonia; in the former not. The disease at Orpington resembled the former. A curious coincidence is the fact that both in 1918 and now outbreaks occurred approximately four years after the beginning of war. In the first place there was a deadly recurrence. Will it happen again? Who knows? It is said that we are better fed now than we were then. I cannot vouch for this as I was in India at that time. There the food was excellent, and yet the "black death" stalked the land. Food may have little to do with it. Most probably it will *not* happen again, but I think medical men and nurses should be alive to the possibility.

I describe now the epidemic at Orpington from notes on forty-seven nurses, young and strong women in the twenties. Over sixty were known to have been affected out of a total of about two hundred, and all but a few stragglers developed it between October 4th and 17th. And here is a very curious thing: very few patients caught it, and not many members of the hospital outside the Nurses' Home. Enquiry revealed that there were some in the town. But whatever the reason may be the disease was strangely local.

Onset.—This was sudden in all cases and most often it occurred in the morning. Often the patient had to leave her breakfast; but be it where or when it might—for instance, at "the pictures"—the patient had to make for her bed without delay. She was well one minute, ill the next.

Rigor.—This was present in three-quarters of the cases. The word is often associated with the idea of shivering, but not correctly. It means at most stiffness, leading to the medical usage coldness. In influenza it amounts to a horrible sensation of goose-flesh, but no actual shivering as seen in the bed-shaking ague.

Collapse.—There was no question of any of the afflicted remaining on duty. Having tumbled into bed they lay there unmoving, seemingly oblivious to aught but their discomfort, desiring only to be left alone. How much anyone could have done we do not know; but, seemingly, the vital functions of life were enough to absorb their energies.

Lividity.—This is a striking feature of influenza sincera. The body as a whole is faintly blue, an effect best seen on the back; but the face, above all, is a leaden blue. I remember seeing one little nurse tottering off to the Home to get her needments with a healthy companion by her side: the effect was most striking. Gazing round the ward on the the young and fair thus prostrated and cærulean one was unkindly reminded of Long John Silver's description of Captain Flint—"a boozy old seaman with a blue mug." This hue must not be confounded with the black colour of the "black death," which is due to broncho-pneumonia. This, the blue one, must be due to some kind of capillary stasis. It was well marked in just under half the cases, being almost constant in the early, and nearly but not quite absent in the later.

Sweating.—Present in all. The skin is clammy and the palms of the hands are particularly wet.

Malaise.—Present in all. There was not a single patient who did not feel ill, and most would reply to the question with a heartfelt affirmative.

Headache.—Present in every case but one, in which gastritis was the prominent feature. It was often enough severe and it was one of the chief sources of misery.

Pains in the Limbs.—The limbs and back ache ; they feel as if bruised and beaten ; but when one examines them nothing is to be found. The meaning of this symptom is, I must say, obscure, but it is very real. Only four escaped it. For that matter what is the backache of smallpox due to ?

The Pulse is soft, compressible and weak ; it is quite different from the full bounding pulse of, say, a streptococcal sore throat ; and this weak, soft pulse is a distinctive feature of what I regard as genuine, indubitable influenza. It is said sometimrs that the pulse of influenza is disproportionately slow, but this was not so in this outbreak. A pulse-rate above 120 was common, and one above 130 was noted several times. The absolute maximum was 150.

Pyrexia.—The usual duration of pyrexia was from two to five days, and the most common duration was four days. The longest, excluding complications, was eight days. The temperature was registered in the usual inaccurate method by the mouth. Very high fever is not a feature of influenza ; consequently the usual maximum in this series of cases, which was between 101 deg. and 103 deg., was true to form.

Tracheitis.—This is the essential lesion of influenza which the revered opinion of the worthy Boyd sets forth (p. 466). Thence it spreads upwards to the naso-pharynx, and downwards, if the patient is unlucky enough, to the bronchi. It promotes a raw feeling between the sternum, little cough, and what there is of it is hard and dry. Just half our patients had the recognisable symptoms.

Pharyngitis.—Influenza is *not* a sore throat. If there should be a bad one, it is a complication. But a single sore throat occurred in this series, with hæmolytic strepto-cocci. This was a complication, almost an accident. Nevertheless, some slight feeling of soreness in the throat was noted by about one-third ; but there was little or nothing to see.

Nasal Catarrh.—So common is the confusion in the public mind between influenza and "a cold in the head," that it must be emphasised that they are quite separate diseases. The amount of nasal catarrh in influenza is small, and there is nothing like a streaming cold, unless it should occur as a complication after the start. Rather more than half these patients had slight nasal catarrh, rather less than half none discernible at all.

Conjunctivitis.—The eyes are suffused in influenza, the ocular conjunctiva glistens dully, secretion seems to be slightly increased and the patient shuns too much light. There were but half a dozen of our patients in whom this symptom was not recognisable.

Gastritis.—This seems to have been prominent in some of the epidemics of the eighteen nineties ; but after this the disease fell to nought, any sort of illness was labelled influenza, there was little or no gastritis in 1918 and "gastric influenza," as it was called, became a sort of joke. But influenzal gastritis is a reality sure enough. It recurred in the mild epidemics of the nineteen thirties ; noticeably, in my experience, in 1934 and 1938. Anyone who takes the trouble to visit the Museum will see what a serious disease it can be. There are specimens of gastritis (acute erosive, chronic mamillary and chronic atrophic) leading to pernicious anæmia, all due to influenza. The character of the disorder is foul. There is utter inability to digest food, frequent vomiting of ropy, tenacious mucus from the stomach, loathing for the sight or the very idea of food and an abominable nausea that makes the patient wish that he or she had never been born. We had but one undoubted case of it, who, even two months later, is still not free from gastric symptoms. But apart from this frank case of gastritis eighteen out of our forty-seven patients vomited, twenty felt sick and the majority could take very little for two or three days. How many of these had genuine gastritis I cannot say, but doubtless some had.

Entero-colitis.—So variable is the virus of influenza that nearly all epidemics seem to have some distinguishing feature. In this one it was diarrhœa. But the effect was not a pure one. Just previously, in the month of September, there had been an outbreak of Sonne dysentery, which was almost a local pandemic. What appeared to happen now was that the virus of influenza attacked the gut, causing diarrhœa and colic in forty-two cases out of forty-seven ; but some of these unhappy maidens were also carriers of the Sonne bacillus hitherto living peacefully and symbiotically with its hostess, or else, maybe, having overtly attacked her and supposedly been expelled. Now was its chance : it took it. There never was a better example of the fact that influenza uncovers any weakness. It was impossible to say how many really had Sonne dysentery, as it was quite beyond the power of the laboratory staff to cope with the investigation ; but out of the worst cases of diarrhœa which were alone investi-gated, about two-thirds had the bacillus in their fæces and one-third had not.

Relapses are a well-known feature of influenza. Two unfortunates, having got over the first attack, within a day or two repeated the whole unhappy story and were left much weakened.

Absent Features.—By far the most notable, of course, was the absence both of bronchitis and of broncho-pneumonia. Evidently in this case the virus did not travel down. One knows not why; one can but be heartily thankful. No one's ear was attacked, another good feature, and no one suffered from inflammation of sinuses. There were no psychical disturbances, no prolonged headaches and no one lost her sense of smell.

Recovery.—Forty-eight hours after her temperature had fallen the patient might feel she was well enough to get up. When she did so the room went round, her knees quaked and in half-an-hour she was glad to be back in bed. It was some days before she was well enough to get about, and even then she did not feel herself. These facts should draw attention to the seriousness of influenza sincera. It is a short, but quite a severe illness. One almost wishes it had a rash.

It may be profitable here to mark off the mild kind that is now proceeding. There is no lividity; there is little sweating; there is some malaise, but much less. The pulse is of normal volume; there is little gastric disturbances and no diarrhœa. The patient neither looks nor feels so ill. She can take an interest in her surroundings, reads a book sometimes and answers brightly when you ask her how she is. "It is not," says Sister sagely, "the same thing." One supposes that the first virus was very poisonous, but had little power of spread; the second has little general effect, but it may yet show more power of invasion.

TREATMENT.

As there is no specific for influenza, treatments consists in favouring the natural powers of recovery, in avoiding mistakes, and in preventing other people from making them. At Guy's Hospital the last should be easy.

Rest.—Rest in bed is essential. Let there be no heriosm. Those who try to keep about are a danger to themselves and a menace to others. "Bed," said a woman to me, "opens its arms to you." It is not merely the sufferer's duty, it is his or her pleasure to go to bed and stay there until better. Another told me, a nurse herself, of the pleasure she felt at the clean neat nurse's approach to her bed. Within the bounds of sense and moderation this is the right spirit for the patient, and anyone who has not got it is suspected of a Jehovah-complex. Rest should be enjoined until at least forty-eight hours have elapsed since the subsidence of the temperature, longer if necessary, and always to be broken carefully and by gradation.

Hygiene.—Influenzal patients do best by themselves. They are a danger to others, and others to them. It is particularly important to avoid any approach of streptococci. To diminish risks of infections the ward ought to be thoroughly well ventilated, and the physician and the sister should be firm on the subject of open windows. Visitors can scarcely be denied, but they do not need encouraging.

Diet.—Theoretically the patient should eat plentifully, especially of protein, in order to repair the wastage of tissues. Practically, few can manage a full diet, and some, especially women, can scarcely eat at all. Attention to the patient's individual feelings is the guide, and as much as he can safely manage without upsetting stomach or bowels is the rule. It is the fashion to give large quantities of fluids nowadays. There is no harm in this, but I am not sure what good there is once the needs of the body have been met, unless it should be in some such disease as pneumonia, where the specific toxin is known to be excreted in the urine. The most refreshing drink for the sickly and the feverish is made of orange-juice, shreds of peel, sugar and water, taken from the refrigerator. But let us draw a veil over the past and do the best we can with bottles strangely labelled S.D.I. (Synthetic Drinks Industry ?)

Sleep.—"In her right hand she held a crystal glass mantling with bright Nepenthe . . . ." Opium is the hypnotic of choice in influenza. Choral and others resembling it in action insufficiently overcome the headaches and pains in the back and limbs. Of course they will serve in a mild case. The preparation named is elegant and not inclined to make the sufferer sick. There is approximately a quarter of a grain of morphine in thirty minims, and a sufficient dose is ♏ xxx for a woman and ♏ xl for a man. But where a patient can sleep comfortably there is no need for hypnotics. I mention this because in hospital patients find it difficult to avoid them, whether they want them or not.

Bowels.—During such a short illness they can be left alone, but if constipation is prolonged a saline can be given. Usually not enough is prescribed. Sodium sulphate gr. 240 is a good dose. I favour personally the elegant effervescing citrate of magnesia invented by Bishop. Should the trouble be the other way, with diarrhœa, morphine is the best remedy. Kaolin is also useful I believe, and usually give it. Morphine relieves the colic as well as the diarrhœa. Atrophine, I found, had little effect on the colic, and the new drug "pethidine," a derivative of piperidine, none at all.

Respiratory Symptoms.—If tracheitis is troublesome the time-honoured inhalations of Tinct. Benxonii Co. are liked by some patients, but whether they really do good seems doubtful. I cannot for the life of me see any possible pharmacological action, and I believe its effect is imaginary. For a dry, troublesome cough codeine, of course; but whereas the old linctus codeinæ made with Virginian prune was palatable, the present linctus is patriotic but repellant. I preferred a daintier mixture of my own composition. For a dry, sore pharynx phenol is the best gargle. It is sweet to the taste and has a local anæsthetic action. It is usually combined with potassium chlorate, which is never in sufficient strength to kill any organisms. The best mixture s of phenol 1–80 to 1–100 flavoured with glycerol and some pleasant herb, such as tincture of myrrh.

Convalescence.—As soon as the patient is fit to travel she is sent off home. A week's convalescence is needed for a mild case, a fortnight for a moderate, and a month for a bad one. If the disease is influenza sincera it is no use paltering with less. There was sent to me a luckless wench in one of the "forces," who had been three days in bed, two days up and then sent back to duty. Her bleary eyes, her quaking limbs, her swollen glands, her troublesome cough, and her strange insistence that she was ill seemed to have puzzled someone. I often wonder whether she got the fortnight's leave I recommended.

Other Matters.—A discussion of any length on the treatment of broncho-pneumonia where none occurred would be inept. In the last war no treatment was of any avail. Now naturally the eyes turn towards the class of drugs called sulphonamides. But the primary invader in influenzal broncho-pneumonia is a virus uninfluenced by sulphonamides and the secondary invader last time was mostly streptococcius viridans, which is unaffected, too. Even hæmolytic streptococci are not all susceptible. The prospect of the new remedies being of any value, should influenzal broncho-pneumonia recur, seems slight.

MISTAKES.

Antipyretics.—There is a popular and successful remedy called veganin, generally pronounced as if it was derived from vegetables. It should *not* be given for influenza, nor should two of its components—phenacetin and acetyl-salicylic acid. Pyrexia is part of the body's defence: to lower the temperature artificially is wrong treatment. In a very mild illness it may not matter much, though it is a scientific offence, but in such a serious disease as influenza sincera it is a bad mistake. If aspirin, say, is given, the temperature falls sharply and the patient is bathed in sweat and becomes somewhat collapsed. No benefit accrues. To demonstrate its effects one patient was made a martyr to science. There was no need to repeat the experiment. I may say that in the last war experience was steongly against giving aspirin.

Expectorants.—Expectorant mixtures are a bubble that needs pricking, but there is no space to do it here. At any rate, in influenza the increased flow of mucus—supposing that the expectorant drug really produces it—seems of no service to the patient. On the contrary, it all has to be coughed up, and yet our efforts are directed to allay rather than to increase the cough. The confusion of mind is well seen by studying some of the prescriptions which contain, say, squills to make the patient cough up more, and tinct. opii camphorata to stop him doing it; or, maybe, it is ipecacuanha to increase secretion and stramonium to dry it up. But inasmuch as these drugs act by irritating the stomach, they ought not to be used at all in influenza. This taboo includes Dover's powder, an ancient and obsolete remedy. Opium is a good drug in influenza, but it is better prescribed in the way I mentioned above; but ipecacuanha makes the patient sick. It was given to one of mine and this was the result it had. If the patient has no gastric symptoms and wants a bottle of cough medicine, then the numerous messes that make up our Mist. Oxymellis Co. will probably not affect him. Even more harmless is Gee's linctus. I remember a child of five drinking a whole bottle of this; he found the flavour so agreeable. Nothing happened.

Purgatives.—Purging is a debilitating and disgusting business that one human being seldom has the right to inflict on another. To have added to the misery of the disease

the griping of the purge, to be dehydrated still further by the outpourings of the bowels, to be compelled to ask for the bed-pan often or to totter feebly to the lavatory, this is to have insult added to injury. No possible benefit can ensue, and yet the old evil still awakes at times and lifts its head. If I were asked to name the worst purgative I should name calomel, a tormenting and unrighteous drug. What many men ought to do is to try the treatment that they give to others on themselves. They might also taste their medicines. They would pick up something of the lost art of prescribing if they did.

In conclusion, I must thank my learned junior, Mr. Laws, for his able assistance and excellent co-operation; and Sister Marson, whom I was heartily glad to call my "invaluable ally."

Speech Re-Education for Cleft Palates

By H. ST. JOHN RUMSEY, M.A.

THE importance of co-operation between surgeon, dental surgeon and speech therapist was emphasised more than twenty years ago by Sir Harold Gillies, when, with Kelsey Fry, he turned his attention to the problem of cleft palate.

In the majority of cases it is the speech therapist who completes the work done for a cleft palate patient, whether his instruction is preceded by the work of the surgeon, the dental surgeon or by their combined efforts. However unfair it may seem, the appreciation of the surgeon and/or dental surgeon is largely dependent on the successful re-education of the speech. Improved speech apparatus will not necessarily result in better speech and in few cases will improvement be evident at once. It is even possible that the patient's speech may deteriorate until he or she has been taught to take full advantage of the improved apparatus.

As an illustration, if a pianist has had to make the best of a thirty-year-old piano, with the felts unevenly worn, he will have learnt to adapt his playing to the inferior instrument. When he has a chance to play on a new first-rate piano in perfect condition, he will not get better or even good results until he has learnt to take full advantage of the first-rate instrument.

Similarly, when the work of the surgeon and/or dental surgeon is completed, thereafter improvement should continue until the speech is up to or nearly up to the normal standard.

Before, however, we examine this re-education in detail it is well to realise that adaptability plays such an important part that in some cases it might be described as *the determining factor. The patient, with little or no power of adaptabillty, will* defeat the surgeon and/or dental surgeon and the speech therapist, who, being the last on the scene, will get most of the blame for poor results! Thus some assessment of the speech of the patient with unimproved conditions should help the surgeon and/or dental surgeon to reach a decision whether or not it is worth while to make a further effort to improve the speech apparatus.

Among the younger generation of speech therapists there is a strong tendency to study the abnormalities of speech in minute detail and, consequently, to lose sight of the ideal at which we should aim. In cases of cleft palate the tendency has been to focus attention on the abnormal consonants rather than to develop the laryngeal tone, which is or should be the foundation of all speech training, whether for the lecture room the stage or the re-education of cleft palates. While it is an indisputable fact that the chief difficulty of the cleft palate is to articulate the explosive consonants G/K, B/P and D/T, it must be remembered that it is the voice that should be the first consideration. Further, it must be realised that undue stressing of the consonants upsets the rhythm of words and sentences and thus defeats its own object, to increase audibility. This depends, first, on the "carrying" power of the voice; secondly, on correct rhythm; stressed consonants are a very badly placed third. This fact was ably demonstrated by the late Professor Lloyd James in a film which he made some few years ago. In this film a Frenchman is heard using absolutely correct vowels and consonants, but by misplacing accents—that is, changing the normal rhythm—he becomes unintelligible to the average Britisher.

So we come to a brief analysis of normal speech, or better, *good* speech, and by *good* is meant speech that is *widely acceptable and easily intelligible.* The three factors concerned in speech are—(1) the breath supply, which provides the force required to

cause vibration in the vocal cords ; (2) the vocal cords which by vibration produce " voice " ; (3) the mouth, which provides the first resonator of the voice (produced in the larynx), and which, with the assistance of lips, tongue and soft palate forms the vowels and consonants.

The foundation of speech is voice and the basis of good speech is a correctly produced voice, a fact overlooked by the majority of elocutionists and even by some speech trainers. Now the *quality* of the voice depends on the correct balance between breath supply and vocal cord resistance. There is a widely spread fallacy that increase of breath supply will result in increased volume of vocal tone, but in actual fact it may be stated that, within reason, the less breath used the greater will be the volume of voice produced. The reason for this apparent contradiction is that volume and quality of voice depend on vocal cord resistance—that is, correct approximation of the vocal cords with, of course, the appropriate *pressure* of breath required to cause vibration. It is obvious that resistance and pressure must be perfectly balanced ; this being the case it may be said that greater breath pressure will produce greater volume of vocal tone, but the fact remains that the volume of breath used will be very small. Thus far we have considered voice production, the foundation of speech, and thus far the cleft palate is at no disadvantage. This fact has not been sufficiently remembered by some undertaking the re-education of cleft palates. There are three excellent reasons for taking every possible advantage of " voice." First, because as I have said, the voice is the foundation on which speech is built up ; secondly, because it is the voice which carries the words formed in the mouth ; lastly, because the cleft palate is under no disadvantage with regard to actual voice production.

Now we pass on to consideration of the part in speech played by the mouth and here we meet with our first real difficulty because it is the work done by the mouth which is handicapped in cases of cleft palate, but we must remember, too, that we are dealing with the superstructure of speech, not with its foundation. As we saw above the first function of the mouth in speech is to provide the first resonator of the vocal tone produced in the larynx. Resonators give quality and " colour " to the laryngeal vibration, and therefore every care should be taken to overcome any defect in the quality of the voice caused by the cleft palate. The hollow, muffled tone which we associate with a cleft palate is, of course, caused by the preponderance of nasal resonance, the nose rather than the mouth becoming the first resonator. This defect can be overcome comparatively easily by teaching forward " placing " of the voice, so that the tone from the larynx is directed on to the teeth rather than to the middle of the palate, where the normal voice gets its resonance until by teaching it is brought forward to the upper front teeth. Much can also be done by exercises to close partially the naso-pharynx and, at the same time, chest resonance should be developed.

In all song and speech both head and chest resonance should be used all the time. In cleft palates whe. the head resonance is nearly always exaggerated and unpleasantly nasalised much can be done, as has been said above, by " placing," but when this is insufficient or the condition of the soft palate makes it impossible to prevent the voice from rising in the naso-pharynx, hyper-development of chest resonance will hide the nasal, muffled tone.

When the voice and its resonance have been corrected and developed the teaching of clear and correct vowels presents no real difficulty. At this point it is well to remember again that clear speech depends—first, on voice ; secondly, on correct rhythm heard in the vowels ; and, lastly and least of all, on clearly articulated consonants. When the last-mentioned are exaggerated audibility is actually decreased. We shall come back to the consonants in a moment ; meanwhile, note that although there are only five, or possibly seven, *vowel letters*, there are no less than twenty-three *vowel sounds*.

We now come to the consonants, but we must not lose sight of the fact even for a moment, that although in the consonants we encounter our chief difficulty, consonants come last in importance because they contribute least to audibility and, if over stressed, will actually be a hindrance to it.

Using the building of a house as an illustration we may compare the voice with the foundations ; the vowels and their rhythm with the walls ; and the consonants with the roof. Many speech therapists have concentrated on a roof suitable for Buckingham Palace and have been surprised at the collapse of the Council house on which they have put it ! Our illustration breaks down only inasmuch as we may have to start with the roof—*i.e.*, the consonants—before the building is ready, but we should think of our consonant drill rather as choosing the timber for the rafters than as actually constructing the roof. We are only collecting the roof materials so as to be ready when the time comes.

A certain amount of hard work and consonant drill must be done if we are to prevent the explosives G/K, D/T and B/P from all sounding alike. Any intelligent parent with a minimum of help from an expert should be able to teach the consonants and this may be done at an early age, the sooner the better. Exercises such as blowing out a candle or inflating a balloon will assist in sufficient closure of the naso-pharynx to get the necessary breath pressure in the mouth. Puffing out the cheeks is also helpful. As soon as the consonants are mastered attention must be turned to the voice, then the vowels and rhythm and for this the help of a voice producer is needed. It is useless to consult an elocutionist who specialises in exaggerated consonants. In the case of an adult both sides should be taught simultaneously.

It is because so many speech therapists have given all their attention to the consonants, the roof of our speech building, and have neglected the foundations and walls, the voice, vowels and rhythm, that the correction of cleft palates has left so much to be desired. At the risk of being accused of " vain repetitions " remember always that speech consists of an outflowing stream of voice and that this stream is partially interrupted for the formation of vowels and continuant consonants, and wholly interrupted for the articulation of the explosives. Thus each of these main factors of speech must necessarily be developed at the expense of the other. A capable speech therapist should be able to keep the balance between the two.

Guy's Christmas Letter

OVER four years of war do not seem to have dimmed the magic of Christmas. A tour of the Hospital revealed that every ward and every department had again turned to and produced every possible variety of decoration, ranging from the purely artistic to the purely ingenious.

The spirit of Christmas was not, however, confined only to the walls of Guy's. Two immense tea-parties were given to the Borough children in the Salomons Centre and in Out-patients ; altogether 350 guests were invited and each received a present from Father Christmas, to say nothing of a tea which ensured heavy demands on the castor-oil bottle in Front Surgery. Not only did Guy's entertain its patients, but the patients

Photo by Norman K. Harrison

entertained Guy's at a shelter-party given by the Hibernia Shelter, where, from "our Daddy" downwards, we were given such a party as is only known to the Borough.

There seemed no end to the food which appeared everywhere in phenomenal quantities, but the Staff surpassed themselves on Christmas night by providing a tremendous dinner complete with turkey and Christmas-pudding.

Once again Matron kindly entertained the Nursing Staff and their partners to dances on two successive nights in the Nurses' Home. Practically everybody in the Hospital was therefore able to attend and to enjoy themselves to the full. Two days later the Guy's Social Club gave their Christmas dance, and, once again, the pace never flagged.

The festivities were finally brought to a close by a New Year's dance held in theatres. A small group of nurses and their friends gathered together quietly to see the New Year in.

Finally, we would like to thank all those who, in one capacity or another, have helped to make this one of the happiest Christmases on record. J. R. T.

Farnborough Christmas Letter

WHAT shall we say of Christmas here? Shall we speak of the decorations, the ward teas, the parties and the dances which have taken place during the past week? Or of the visit of Santa Claus to the children, the joy of the patients, and their gratitude for the extra efforts made by the Nursing Staff to provide them with a really enjoyable time? Because, for one and all, from the highest to the lowest of the Hospital hierarchy, this has been a grand Christmas.

On Sunday, December 19th, a carol service was held in the Chapel. The choir, under the leadership of Dr. Rewell, sang the carols with spirit and effect; while Miss MacManus and Mr. Davies Colley were amongst those who read the lessons.

The decorating of the wards took place on the days preceding Christmas, the workers being rewarded for their labours by magnificent teas. Lord Woolton might have frowned at their excellence. Carols were sung around the wards on Christmas Eve, the bass voices of the few remaining students almost being overwhelmed by the singing of the nurses.

On Christmas Day a lunch was given in "H" Hut, attended by Miss Cooke, the Matron, and members of the nursing and medical staff. Sister Dorothy proved herself extremely adept at carving the turkey and the lunch was delicious. Mr. Carnegie then distributed presents from the tree.

The children's ward was visited twice by Father Christmas. He was followed by a nurse, armed with safety-pins, to administer constant first-aid to his nether garments, which kept slipping off.

The day was rounded off by a very enjoyable party held in Bromley Ward.

There is neither the time nor space to mention individually the activities which continued throughout the week. There were parties in the various wards, each so well planned and so successful that it would be difficult to choose between them. The Nurses' Dances were held on December 28th and 29th in the dining hall, followed by the Servants' Dance on December 30th.

We hope that all at Farnborough will agree with us in saying that Christmas at this hospital was the best it could possibly be. J. F. C.

Correspondence

GUY'S CENTENARY MATCH.

To the Editor of the GAZETTE.

SIR,—I read with pleasure your account of the centenary match and celebrations. I was amused at the idea of a grey-headed old-timer springing up and saying that he played for Guy's in 1843, because I can claim a close association with him and his fellows even before Guy's Rugby Club was founded.

In a copy of the *London Medical Gazette* of 1841 which I have, my father is noted as having qualified in April of that year; he was at Guy's, and I have personal testimonials given to him by Bright and Aston Key in 1841 and others from Cock, John Hilton, Barlow, Callaway, etc., in 1844, so he must have known members of the 1843 team. My father was twenty-six when he qualified; he married late and I was born in 1867; he died in 1870 in Australia.

I do not suppose this is a record, but there cannot be many with so direct an association with Guy's in 1843. I had hoped to be at Honor Oak, but the weather was a bit too rough for my seventy-six years.

Yours, etc.,

36, Budhurst Rise,
South Croydon.

H. M. BERNCASTLE (Guy's 1893–1899).

Sport

Rugby

GUY'S *v.* R.N.E.C. (DEVONPORT).

The Royal Naval Engineering College, Devonport, paid their third visit to Honor Oak Park on Saturday, December 18th, 1943, but, after a gallant struggle, the Hospital beat them by a goal and a try (8 points) to a try (5 points).

From Guy's point of view there were many satisfactory features, the most important being the improved understanding between Graham, N. K. Macrae-Gibson and Strathie. At times their passing and cutting through were so beautifully executed that one wondered why more tries did not come, but the College defence was almost like a brick wall.

The diminutive scrum-half Willcock took a lot of knocks, but the forwards were admirable in the way they helped him, and at the same time took care of themselves when things became more vigorous. Nobody played better than Batty-Shaw, and this in spite of a nasty ear injury.

The first half definitely went in favour of the Hospital who thoroughly deserved a try by N. K. Macrae-Gibson, who ran stoutly for the line, after Strathie had made a big gap in the College defence. Gullick converted. They went further ahead when Batty-Shaw gathered from Gullick's cross-kick, and Brittain finally got the ball for an unconverted try.

The College made several dangerous attacks in the second half, in which Lieutenant Hairs was always prominent, and it was he who scored a try for Lieutenant Mares to convert. It was a treat to see the excellent tackling of the Guy's backs whenever the position became threatening, and Hildick-Smith once again proved himself a first-class full-back.

Team.—G. Hildick-Smith; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. M. Strathie, D. C. Boyd; E. W. Graham, R. D. Willcock; A. Batty-Shaw, A. B. Lee (captain), R. A. Dean, I. H. Hilliam, D. L. Gullick, R. G. L. Brittain, C. Vidot, P. D. Harvey.

During the Christmas holidays A. B. Lee played for Barbarians against Thorneloe's XV, which included D. M. Strathie; and A. Batty-Shaw and E. W. Graham were honoured with places in the London team against The Dominions and Richmond. Congratulations.

Hospital Information, etc.

Pass List

EXAMINING BOARD IN ENGLAND.
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December, 1943.

Anatomy.

C. J. Johnson	A. J. L. Wheatley
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Physiology.

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ROYAL COLLEGE OF SURGEONS OF ENGLAND.
L.D.S.
December, 1943.

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(Properties of Dental Materials.)

P. C. Hadley	M. J. L. Sykes

SECOND EXAMINATION.

PART 1.—*General Anatomy and Physiology.*

P. H. Prynne	J. R. Timms

PART 2.—*Special Anatomy and Physiology.*

J. E. De Bondt	J. D. Green
J. E. Dyke	G. R. M. Mote
D. J. Gray	A. E. Trist

PART 3.—*Dental Mechanics.*

R. Freeman	W. D. Hannaford
H. C. Goudge	W. O. King

UNIVERSITY OF LONDON.
3RD (B.D.S.) EXAMINATION IN DENTAL SURGERY.
December, 1943.

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T. D. Birtwhistle	R. J. Hart
J. C. Cox	R. A. Ronchetti
E. A. Glover	C. E. Stuart

Supplementary Pass List.

GROUP I.
B. N. Joyce

GROUP II.

N. J. Crane	A. D. Robinson

2ND (B.D.S.) EXAMINATION IN DENTAL SURGERY.

PART I.

S. J. Bell	J. C. Schofield
G. B. Elphicke	J. T. Woodall

The following Students have been credited with Anatomy and Physiology:—

H. M. Hughes	D. G. Jones
S. P. Johns	J. D. Morgan

PART II.

S. G. Le S. Beaton	N. T. McNeil

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

IN a few weeks, possibly during March, almost certainly before the end of May, the first- and second-year students are to return from Tunbridge Wells to Guy's.

Tunbridge Wells, as a non-industrial town, must originally have welcomed the Guy's evacuation scheme—a gesture of comradeship arising from the declaration of war. The " young doctors " not unnaturally caused interest in a society where doctors had for long been a topic of more than ordinary import. But nothing momentous happened on the battle-fronts, there were no more sandbags to be filled, time slowed down and our hosts were able to relax, to take stock again, this time of Guy's making themselves at home in their own and, we hope, not really displeasing fashion. We were soon relegated to being " students " and, amongst other attributes, were " always having coffee," " always going to the cinema," " never doing any work." A contemporary journal was very outspoken on the subject. All this was ill-deserved and resulted partly because 450 students, no doubt looking confusingly similar, are perfectly capable of being everywhere at once ; more because, as the strength of a chain lies in its weakest link, so the reputation of a community commonly rests with the behaviour of its worst characters ; and, finally because, with every respect, the rival outlooks, suiting their respective ages, clashed. However, even the most confirmed Tory is not completely obstinate and opinion slowly became more favourable, so that for the remaining three years all went happily.

Out of this enforced transference of the School arose the idea of establishing the Preclinical periods (in the broader sense) permanently at Tunbridge Wells. A number of the basic requirements were already available ; others have been added during the four years the School has been there. It would be idle presumption on our part to attempt to weigh briefly, yet at all adequately, the arguments and interests involved, but it is a subject which has warranted more general thought than has been given to it.

By the test of evacuation several advantages of the scheme are obvious. Tunbridge Wells had proved a far more healthy place than the Bermondsey and Southwark areas, quite apart from a desirable minimising of travel—advantages which became even more real as, in step with the modern trend in education, those taking up medicine or dentistry are compelled to do so at earlier ages. It would be interesting to conduct a ballot among students who have studied at Guy's and Tunbridge Wells on their preference for the social life of one or the other, bearing in mind that in any case three years would be spent at Guy's itself. Few, in fact, regret having been at Tunbridge Wells for those two years. To be considered also is whether Guy's should be a teaching centre for Londoners primarily or—we say it with hesitation—the Empire ; for on this turns the most potent objection advanced by students—that a largish minority have had to leave home, which, whether an advantage in itself or not, is certainly a large additional expense. But for the return the more enlightened outlook of the School Council has decided the issue. They are in a position to appreciate more exactly the difficulties and drawbacks arising from isolating a large group of students together with the appropriate teaching staff. Further, they are able to judge the financial aspects with greater insight—the hostel system which has been a *sine qua non* in the evacuation and ideal for those who are fresh from school, has proved to be a luxury that could not last indefinitely.

Once the principle of returning had been sanctioned by the Government the School at Guy's set about preparations to receive this increase in numbers. Laboratories and theatres, which had been temporarily allocated for various unaccustomed uses, have been reclaimed. Meanwhile the Students' Club has been acting to provide restaurant accommodation and other amenities. Two rooms are being prepared above the old Pathology theatre for recreation and reading. The present restaurant—formerly the

Staff common room—may be required again by the Staff; instead it has been deemed possible to recommission the partly "blitzed" dining-room in the College. It is over the grant of permits to carry out the necessary alterations in this case that delay in the final return of the School may arise.

ABOUT this time last year a note was made in "Passim" concerning subscriptions so that we might save both postage and paper. They are again due for the *Gazette* and "Directory of Guy's Men" (Medical and Dental)—12*s*. 6*d*. per annum, post free. Letters should be addressed to the Manager, the *Gazette* Office, Guy's Hospital, S.E.1. Last year, we are informed, seven replies were received. Can this be excelled?

Blood and Iron

A Clinical Lecture delivered at Guy's Hospital by Dr. A. H. Douthwaite, November, 1943

GENTLEMEN,—Iron is essential to the life of every cell in the body, for it plays a part, probably as a catalyst, in the oxidative processes of living tissue. Its importance in the production of hæmoglobin tends to overshadow this fact.

Distribution in Body.—There are about 3½ G. of iron in the body, two-thirds being in hæmoglobin. The liver, kidneys and spleen account for most of the remainder, whilst traces are found in the living cells of other organs. It is stored in readily available form in the liver and spleen, so that it can be transported to the bone marrow for hæmoglobin requirements.

Source of Iron.—Normally the daily supply of iron is obtained in organic form in which it exists in relatively large amounts in spinach, watercress and green beans (about 5 mgms. per 100 G.) and in liver (15 mgms. per 100 G.). Bread, potatoes and cows' milk contain only a little, but human milk is at least three times as rich in iron (2 mg. per litre) as is cows' milk. This is a matter of importance in that breast-fed babies seldom suffer from anæmia whilst bottle-fed infants may develop a severe nutritional anæmia. The new-born child starts life with a good store of iron, but on iron-deficient food it will eventually develop anæmia because some iron-loss is taking place by excretion through the large gut. It is estimated that the mother supplies the fœtus and later the child, during pregnancy and lactation respectively, with iron rising to 2 mg. daily.

A satisfactory diet for an adult should supply 15 mg. daily.

Absorption.—A long controversy has centred around the question of how iron is absorbed. At one time it was thought that inorganic iron was never absorbed and that the body's supply depended on the organic compounds present in the food. Modern views are in the opposite direction. It seems likely that the complex organic iron compounds consisting of non-ionisable iron have to be broken down into smaller molecules and probably converted into the ionised form before absorption. Inorganic iron is certainly absorbed, possibly only after conversion to the ferrous form. Hæmoglobin which suggests itself as a natural food supply of iron is quite useless in this respect. Iron is not released from it by digestion so that only 20 per cent. of iron in meat is absorbed.

It is possible that ferric iron is reduced in the stomach and duodenum to the ferrous form. This process takes place readily in the presence of easily oxidisable substances such as exist in the food in the stomach and is favoured by an acid reaction. In the absence of HCl organic acids play their part. When iron reaches the part of the intestine in which the contents are alkaline, it is precipitated as an insoluble phosphate and can no longer be utilised. In the large intestine the metal combines with hydrogen sulphide and is passed in the fæces as iron sulphide.

It will be seen, therefore, that in the course of its transit through the alimentary tract little time is allowed for its absorption, but this is normally sufficient in view of the small daily requirements of a healthy individual.

Should, however, repeated bleeding occur, iron deficiency will soon show itself and then large doses of the most readily absorbed compounds must be given to make good the loss and to build up depleted reserves. It is of interest to note that women lose from 0.02 to 0.1 G. of iron monthly. It is estimated that only one-third of the iron in food is absorbed, therefore the adult female needs about 10 mgm. of iron daily to main-

tain a balance. Repeated small hæmorrhages from piles are another common source of severe iron-deficiency anæmia.

Almost the whole of iron absorption takes place through the duodenum, a little being taken up by the jejunum. It is absorbed intracellularly, possibly by an active process of the epithelial cells. When iron is deficient in the food it is absorbed with avidity. When it is present in plenty over a long period the excess is rejected as if the epithelium were endowed with some descriminating power. A good deal which cannot be utilised or stored is, however, absorbed and then excreted by the epithelium of the large gut.

Excretion.—On a normal diet iron is excreted chiefly by the large intestine in amounts up to 8 mg. daily. On an iron-poor diet this falls quickly to 1 mg. daily and remains at this level. Practically none of the metal passes out in the urine. If iron preparations be injected intramuscularly there is an increase of intestinal excretion.

Action.—Inorganic iron preparations in solutions exert an astringent effect. The ferric salts are the most powerful, causing precipitation of protein with intense irritation and inflammatory reaction. Iron perchloride is the most powerful in this respect. The teeth and tongue are blackened on account of sulphide formation if iron in solution is taken by mouth. The œsophagus and stomach may be irritated and give rise to heartburn, abdominal pain and vomiting. The astringent action is continued in the bowel and thus constipation is produced. In some persons the irritant action outweighs the astringency and causes diarrhœa. The ferrous salts may also irritate the stomach and cause symptoms which may be troublesome during treatment.

Headache, giddiness and, rarely, evidence of true encephalopathy with confusion and excitement may arise from the action of iron on the brain. It seems likely that it indicates an unusual power of absorption of the metal together with an abnormal sensitivity towards its action. Only large and prolonged doses produce it.

Iron salts precipitate blood proteins and have thus given rise to fatal embolism when used for injection into nævi. The same action gained them a reputation as styptics, but their use has been superseded by more efficient and less hazardous drugs.

Internal.—The two main actions of iron after absorption are the furthering of oxidative processes and the formation of hæmoglobin. Of recent years interest has centred on the latter function by the discovery that it was dependent on the presence of a minute quantity of copper. This metal appears to be necessary for the final stage of hæmoglobin formation. Copper deficiency is very unlikely to occur in the adult, but bottle-fed babies may be short of iron and copper, so that the administration of ½ to 1 mg. of this metal in addition to iron may be found necessary. In Whipple's experiments which ultimately led to the discovery of the liver treatment of pernicious anæmia it was noted that dogs rendered anæmic by repeated bleeding recovered more rapidly on iron plus liver ash than on iron alone. The ash contains copper as well as iron.

Therapeutics.—The chief use of iron for its local action as an astringent is for sore throats. It is often combined with potassium chlorate, *e.g.* liquor ferri perchloridi drachms 2, potassi chloratis grs. CX, aquam ad 8 ounces; ½ ounce to be diluted with an equal part of hot water to be gargled and swallowed. It is the swallowing which is advantageous in that the fluid reaches the tonsils and the posterior wall of the pharynx. It is used for the same purpose, though less effectively, as reduced iron lozenges each containing 1 grain. For capillary oozing iron perchloride or a ferrous sulphate solution may be used as a styptic.

Five per cent. solutions of iron salts may be employed as astringents in certain forms of dermatitis, notably that due to poison ivy. There is a danger, however, of permanent pigmentation of the skin being produced.

The use of iron to check bleeding from the stomach or duodenum is now a matter of historical interest. Even when bleeding comes from minute ulcers associated with gastritis, iron would not be suitable because of the irritant action of the soluble salts.

As an astringent to check diarrhœa it is far less effective than crude tannin-containing drugs or chalk and opium.

Internal.—The outstanding indication for the use of iron is anæmia, especially the hypochromic varieties. In this condition our thoughts turn naturally to chlorosis in spite of, or perhaps because of, the fact that the disease no longer exists. It provides one of the most remarkable examples of the disappearance of a once common malady. It flourished in Victorian times as the "green sickness." It affected almost solely the

town dweller and was practically confined to women. It was no great respecter of class, for it attacked the undernourished, overworked and underpaid servant girls of those days of piety and humbug as also her mistress's daughters. They were thus able to swoon with ease to meet emotional crises. The servant-girl was frankly undernourished whilst the well-to-do young lady took but little exercise, tight-laced, ate the wrong foods and was constipated. In consequence her periods were excessive and painful. It is difficult for you to realise that in those days the subject of bowel action was taboo. "Ladies of quality" possessed neither bowels nor libido sexualis. The repression of both hampered the attainment of what is known in modern parlance as "positive health."

Chlorosis followed Queen Victoria fairly quickly to the grave, diminishing rapidly during the more robust Edwardian period to disappear in 1910. It was about this time that gastric ulcer in servant-girls became a rarity and duodenal ulcer in men became a noteworthy disease.

However, to revert to iron, it was found to be a specific for chlorosis and, because anæmia was so common in those days, it earned a reputation of being a general tonic.

To replace chlorosis of young women we now have a similar hypochromic anæmia of the middle-aged woman—namely, microcytic, hypochromic, achlorhydric anæmia. There is no reason to suppose that it has not occurred for centuries, but only recently, largely due to the writings of Witts, has the disease been recognised. The picture of such an anæmia coupled with smooth tongue, flat finger-nails, achlorhydria (not achylia) and possibly an enlarged spleen is familiar to most of you. Once again response to iron administration is excellent and complete restoration of health ensues. The absence of hydrochloric acid from the gastric juice is probably of great importance here yet, given sufficient iron, recovery takes place without simultaneous administration of acid. The suggestion that iron is only absorbed after conversion to ferrous chloride is probably incorrect, therefore. It should be remembered that in conditions of achlorhydria and achylia the pylorus tends to remain open and the stomach and duodenum to empty rapidly. This hurried transit is probably of prime importance in preventing adequate utilisation of iron contained in the food.

Clearly iron is indicated for nutritional anæmias—*e.g.*, infants fed on cows' milk or any other condition of insufficient iron intake or absorption. Ascorbic acid deficiency causes microcytic anæmia. Iron should be given in addition to correction of the vitamin lack.

Anæmia due to hæmorrhage, especially if repeated—*e.g.*, from duodenal ulcer or piles—should be treated with iron because the store in the liver and spleen will have been called upon and may be seriously diminished.

In hæmolytic anæmias—*e.g.*, malaria, acholuric jaundice, etc.—much iron is lost by excretion and its replacement is indicated.

Many acute infections are accompanied by anæmia and convalescence may be needlessly prolonged by the failure to recognise the value of iron therapy.

Although the treatment of pernicious anæmia consists chiefly of the injection of liver extract, it must be remembered that the achylia of this disease favours the non-absorption of iron. Liver treatment restores the red cell count to normal, but the hæmoglobin lags behind and may be held up at 75 to 80 per cent. Iron therapy should, therefore, be combined with liver treatment. It is a curious fact that liver has some curative action on nutritional anæmia quite distinct from its iron, copper or hæmopoietin. Liver, iron and copper give better results than any combination of two of these.

Choice of Iron Preparation.—From what has been said of the absorption of iron it will be clear that inorganic iron is preferable to organic iron, and ferrous to ferric salts. Reduced iron might with advantage be eliminated from the B.P. The use of iron perchloride has been discussed in relation to its astringent action. It is most unpleasant to take, far less effective than ferrous salts for anæmia and should never be given for this disease.

The scale preparations, of which only iron and ammonium citrate need be considered, and various ferrous salts deserve attention. Witts has done great service by investigating their relative efficiency.

The scale preparation of ferric iron has the advantage of being only slightly astringent and can, therefore, be taken by persons who always suffer from heartburn or other forms of indigestion after taking the simpler compounds. Again, the

solution is stable if made with chloroform water, and can be combined with other active drugs apart from mineral acids, fixed alkalis and vegetable astringents. On the other hand, it is relatively costly and must be given in large doses—viz., 90 grains daily —to be effective. It is of special value in the treatment of anæmia due to bleeding from the stomach or duodenum, or due to gastritis. In such cases it is its relatively non-irritant action which is of importance. Ferrous carbonate is the active principle of Blaud's pill. This is a soluble salt, but prone to conversion to ferric form in solution. In the pill it is mixed with glucose to prevent oxidation. The pills must be of recent manufacture to be effective, for they are liable to desiccation and will then pass through the alimentary tract unchanged. Iron carbonate is also present in Ferri Carbonas Saccharatus (10 to 30 grains), which is useful for administration to children. It is only slightly astringent, but is hygroscopic. In giving ferrous carbonate not less than 45 grains should be administered in divided doses daily to the adult.

Ferrous sulphate and ferrous chloride are the most efficient of all the salts. The B.P. contains ferrous sulphate (1 to 5 grains) and exsiccated ferrous sulphate (½ to 3 grains): 3 grains of the latter—1 grain Fe.. Ferrous chloride is official as Ferri Subchloridum Citratum (3 to 5 grains). It contains not less than 68 per cent. of ferrous iron and not more than 5.8 per cent. of ferric iron (5 grains — 1½ grains Fe). The sulphate and the chloride are both readily utilised and the latter is probably absorbed unchanged.

The effective dosage of the ferrous sulphate and citrated chloride is not less than the maximum B.P. dose given four times daily. It will be seen that the total needed is very much less than that required for the scale and ferric compounds. In all cases iron should be given after food. It cannot affect the hæmoglobin content of the cells already in circulation, but rather those about to be formed. A lag consequently exists between the beginning of administration and the improvement in the blood picture.

As to injections of iron, the official Injectoi Ferri (15 to 30 minims by intramuscular injection) contains the equivalent of 1/10 gr. Fe in 30 minims. The administration of the injection is followed by an increase of iron excretion in the fæces. Even double the B.P. dose is small compared with iron given by mouth, but it must be remembered that much of the latter is not absorbed. On the other hand, the form in which iron exists—namely, a double salt of citric acid and ammonia—does not present an assimilable preparation as far as we know. In any case it is very rare for injections to be needed even for patients who declare they cannot take iron by mouth. If the nature of the drug be masked they usually consume it without untoward symptoms.

Finally, a word about chlorophyll. This substance contains no iron, but closely resembles hæmoglobin in structure. The former is a magnesium-porphyrin, the latter an iron-porphyrin. There is no evidence that chlorophyll alone is of value in correcting anæmia. Green vegetables contain both iron and copper apart from chlorophyll. There is, however, some evidence that chlorophyll combined with iron is more effective than the same dose of iron alone. This is of doubtful importance because iron therapy is so excellent in its results ,but I have raised the point in view of the claims made for various chlorophyll preparations on the market.

Another Letter from "Sinbad"

DEAR BILL,—I suppose that things are getting near your departure and that you are hurrying around making preparations for the great day. I hope this and my next letter will reach you in time to be of some use. First about books. I do not agree with the official view about them ; this is that you should be content with as few as possible of your own and that the ship's medical library should suffice. For a destroyer this consists of five books, excellent in themselves, but you must judge how you would care to depend upon them for single-handed diagnosis, treatment and nursing a thousand miles out in the Atlantic—and this is not a hypothesis. I am writing at the moment from that exact situation. The books provided are Manson's "Tropical Diseases," an Index of Treatment, Burke on V.D., Woolmer's "Anæsthetics Afloat," and a surgical book which I have not yet got. The doctor in a small ship is cut off from the advice and criticism of his friends. True there are M.O.s in other escort vessels, but boatwork in the Atlantic is seldom possible in winter, and he may have to work in complete isolation for as long as a fortnight, a situation seldom found in either of the other services ; very often he has only a few months' hospital experience.

His books are his friends and advisers. This is only one aspect of the problem; he must continue his systematic reading, eking out his slender clinical material with extensive reading, making the most of his opportunities so that when he returns he will have a store of theoretical knowledge to turn to immediate practical use. If your ship has a U.S. Navy Library you are lucky, since it contains a much larger selection of books. I think that the official attitude is based upon the destroyer doctor of the last war, who was often a fourth or fifth year medical student, and who might have been confused by a large array of books. In those days the extensive trips now done were not made and the destroyer M.O. did not expect to be at sea more than three to four days.

My minimal list is as follows. I think it unwise to go to sea with much less and you could well take more. Where I have named my particular choice of author you may choose another, but the books marked with an asterisk have special virtues for their inclusion.

Surgery.—Illingworth; Pye's "Handicraft"* Hamilton Bailey's "Physical Signs"; Mark Iselin's "Surgery of the Hand."*

Surgical Anatomy.—Grant Massie.

Medicine.—Conybeare; Dunlop Davies and Macnee; Chamberlain's "Physical Signs."*

Skins.—Roxburgh and Kenneth Mellenby's "Scabies"*—an excellent monograph on this prevalent disease.

Psychiatry.—Henderson and Gillespie* and Ross's "Common Neuroses"*—psychiatric patients are numerous in the Service and mild anxiety states respond well to simple therapy, while it is essential to recognise psychoses as early as possible.

Pathology.—Boyd's "Internal Diseases."

Neurology.—Walshe.

E.N.T.'s.—Scott Stevenson*; Oxford War Manual, which I bought after reading its review in the *Gazette*, has already (in three weeks) been of the greatest use.

Pharmacology.—Mick's and Martindale.* The former is a pleasantly sceptical book and the latter will help you to decide what the various proprietaries, especially the transatlantic ones are.

Physiology.—Macleod.

Eyes.—Morgan's "Opthalmology in General Practice."

Macdonald's "Shipwrecked Survivors" is a fine book, covering a subject with which you are certainly ignorant and will require advice and help.

I have no doubt you subscribe to one of the medical journals and will have plenty of time to read them. The "Medical Research Council's Bulletin of War Medicine," with its accurate abstracts, provides fascinating reading and solves the problem of keeping in touch with world medicine in your solitary practice. The "Bulletin of Naval Medicine" is obtained by ordering from the R.N. Store Depot. It is a small publication, each issue dealing with about ten subjects of current interest in naval medicine. It is useful not only for this, but at the end of each issue is a list of A.F.O.s (Admiralty Fleet Orders) of medical interest. These A.F.O.s are very puzzling at first. But it is well worth while reading them every two to three months, since they contain a good deal of information. I keep a notebook in which those I consider relevant are noted. It is much easier to get stores, etc., if you quote the A.F.O. concerned than if you say vaguely that you think you are entitled to the article in question; sometimes even, an A.F.O. number and a bold face will get you things you are not strictly allowed. King's Regulations and Admiralty Instructions (K.R. & A.I.) have a large medical section which is to be waded into occasionally; it is as well to look through these voluminous notes occasionally because you cannot avoid having references to them in your correspondence, especially regarding your journal. There are a large number of official books which A.F.O.s advise you to get and be sure you do so. Many of them are M.R.C. pamphlets, but others are specially written for the sea, the information is concise, up to date and free. If you can persuade a "chippy" (carpenter) or someone to make you a box containing shelves, this will be an excellent way of storing your books and allow you to transport them easily.

My second piece of heresy is about surgical instruments. I expect that by now you have accumulated some favourite tools in your small dresser's pack. The Admiralty take no responsibility beyond a stethoscope and one or two "essential

instruments " —an attitude, again, I am sure, based upon last war experiences of short trips. The official instruments and drugs are, as I've said before often very good, but everyone has his own likes and dislikes, and you will find that there are so many difficulties in lone work at sea that it is worth risking your gear to get good results.

I carry 2 cc. and 10 cc. " Record " syringes with a selection of needles from the finest hypodermics to 3-in. 20-gauge for deep infiltration and regional local blocks. Needles are a problem in all the Services, especially since their bluntness and the resulting unnecessary pain undoubtedly account for some of the objection to inoculation. A small Arkansas stone, costing 5*s.* to 6*s.*, solves this difficulty. You will find that it is a simple matter to keep a first-class point on them, and once you have mastered the art, you should teach your S.B.A. Larger units should have one man devoting a certain amount of time each day to it. Intravenous needles are better for a short bevel ; those provided usually have bevels more suitable for intramuscular work. The lumbar puncture needles are altogether too massive ; a fine one in nickel that fits a Record syringe and will not snap will help in giving spinal anæsthetics as well as in the diagnosis and treatment of head injuries. Fine scissors such as used in opthalmology, splinter forceps, a good needle-holder and a small scalpel are useful additions to your original dresser's instruments. Recent experience suggests that a peracentesis knife should also be carried, but I am investigating to find out the best sort—one with a protected blade would seen indicated. An Evans's vein seeker, as described in Pye, gives one moral support. I haven't had to use mine yet, but the thought that if I cannot find a vein I have this in reserve is reassuring. I am thinking of getting a sternal puncture needle for transfusion work, since severe burns of the arms and forearms are liable to make intravenous fluids difficult, or Dunlop and Billemorre's intramuscular needle might be used. Although it is not possible to do many investigations on board a pair of sedimentation tubes are easily carried and are a good check upon those who have suspicious chest histories. I believe that Hawksley's new micro-method would be the most suitable for a small ship, and I am indebted to Dr. R. E. Rewell for this suggestion ; at the moment I use two tubes cadged from a U.S. Navy aircraft carrier.

I expect that by now " science's latest sea-sickness cure, secret until the end of the War " is being enquired about in your sick bay. I found tinct. belladonna 10 to 15 minims tds. fairly effective and you will have read the official recommendations. Sea-sickness *en masse* is an awe-inspiring sight ; in a few hours your cheerful sailor lads are transformed into wan grey ghosts cowled in duffel coats. After some weeks ashore even experienced sailors feel uneasy and irritable for the first two or three days of the trip. I have read eloquent Press accounts about worn and haggard sailors coming in from the Atlantic battle ; this must happen occasionally, but the dullest observer recognises that there are few sprucer and jollier sights than an escort ship coming in from convoy duty with the work done and the prospect of leave, while the first two days at sea are noted for malaise and ill-temper.

Classically the Doc. is the mess secretary and wine caterer, and if you have any aptitude for this take it over, but not during your first month at sea. Executive officers seldom realise that in four to five weeks you have covered ground which took them several years, and that you are trying to adapt yourself and your work to conditions utterly different from anything you have experienced and that you may have no marked ability for catering or accounting. Should you decide to do it, before taking over have an audit, however unnecessary this may appear and however simple the situation may seem. You will certainly be asked to assist with cyphering and should do so to the best of your ability, although I doubt the wisdom of the doctor doing any full-time job outside his own work. The old attitude that he has unlimited spare time should be incorrect because he must read for several hours each day to keep himself in trim.

Personally I consider the ship's censoring to be your most useful function. Censoring should never be done communally, although this is often so ; it is very difficult not to comment upon the lad who writes eternal love to two or three parties, or the other, who describes the crash of the high seas and the terrible rolling which prevents him writing more when the ship is moored alongside, but if you start talking in the ward-room the stewards will also hear your remarks and they will find their way back to the writers, who will have a justifiable natter. Censoring is important for positive reasons ; it is one of the means of judging the morale, discovering and righting the grievances and helping to allay the worries of the ship's company. Letters sent home and letters from home are a prime factor in maintaining the morale and, as mail officer, you will be able to see that they always get away without delay. This may mean one or two

hours' work at night. Censoring is purely a matter of cutting out dangerous information; opinions must never be censored, but if a sailor who normally writes cheerfully becomes bloody-minded an immediate investigation should be made. I have not found this is resented. When you do this do not censor the latter, but simply say that you would like to help if possible, but that you cannot prevent a man from writing what he pleases. By doing all the letters you get a full perspective of the feeling among the ship's company and can assist the executive officers by informing them about this in general terms. From a medical view-point it means that you have a window into your patients' lives which might take years to achieve in ordinary practice and is usually impossible in service conditions. If I were you I would plump for censoring.

Au revoir,
Your Surgical Seadog,
"SINBAD."

H.M.S. *Verucca*,
c/o G.P.O., London,
December, 1943.

P.S.—I note with some surprise that I have made a shocking mistake in my last letter. No merchant seaman ever called scuttles "dead-lights"; it should be "port-holes." I told you I'm not a sailor, but three experienced sailors read that script before one spotted it. Among books don't forget Pickle's "Epidemiology in Country Practice." I haven't had an epidermic yet to try his method; you may be unluckier or should I shock my shipmates and write "luckier"?).

Correspondence

INFLUENZA.

To the Editor of the GAZETTE.

SIR,—I was much interested in Dr. H. St. H. Vertue's observations on "Influenza," published in his *Gazette* essay (January 8th). That the disease is manifold in its manifestations is well known. Mr. T. B. Layton, writing in the *Gazette* in January 1933, said: "Of all the diseases of which I know influenza is the most exhilarating and most exciting with which to deal. In my experience, malaria alone rivals it in the protean nature of its manifestations."

In Dr. Vertue's series of forty-seven cases (nurses at Orpington Hospital) I was struck by two of his findings—namely: (1) that there was little or nothing to see in the throat; and (2) that tracheitis promoted a raw feeling behind the sternum, but only little cough, which was hard and dry.

While at Queen Mary's Hospital, Sidcup, which is not far distant from Orpington, I was privileged to see over a hundred cases of influenza, nearly all of them in young men and women in the Services. What struck me particularly in this series was: (1) the very troublesome dry, hacking cough and (2) the typical appearance of the throat in almost all of the cases, where the mucous membrance over the fauces and soft palate was red and infected, but without tonsillitis.

Great significance attaches to Dr. Vertue's pronunciation that influenza uncovers any weakness. He quotes the Sonne dysentery episode. My particular interest is diabetes. We are all aware of the bearing of infection on pre-existent diabetes, but uncertain about the role of organisms in precipitating diabetes. Some authorities maintain that there is some relationship between diabetes and a preceding infectious episode. Jones commented on an increasing incidence of diabetes after epidemics of influenza. (Quoted by Van Noorden, C., and Isaac, S.: "Die Zuckerkrankheit und ihre Behandlung." Ed. 8, Berlin. Julius Springer, 1927, p. 291.)

My own view is that infection, which may precipitate diabetes in an individual with a biologically inferior pancreas (in other words, a predisposition to th edisease), is not a major etiological factor. But in view of the statement of Jones, and Dr. Vertue's maxim that influenza uncovers any weakness, I should be interested to hear whether this observation can be corroborated, and, if so, how is the present 1943–1944 epidemic going to influence the morbidity of diabetes?

Yours, etc.,
GEORGE R. W. N. LUNTZ, M.R.C.S.,
Medical Officer, Guy's Unit, E.M.S.

REBUILDING OF GUY'S.

To the Editor of the GAZETTE.

SIR,—In these days when there is so much talk of post-war planning, it has come to my mind that when the plans are drawn up for the rebuilding of Guy's, could a small room or chapel for Catholic nurses be taken into consideration ? I feel sure that if this could be done many former students and nurses would be glad and very willing to contribute towards it.

I am writing to you about this, as in that way many would get to hear of the suggestion, and perhaps express their views.

Yours, etc.,
GLADYS A. R. REES.

207, Romford Road,
Forest Gate, E.7.

CLUBS' UNION.

To the Editor of the GAZETTE.

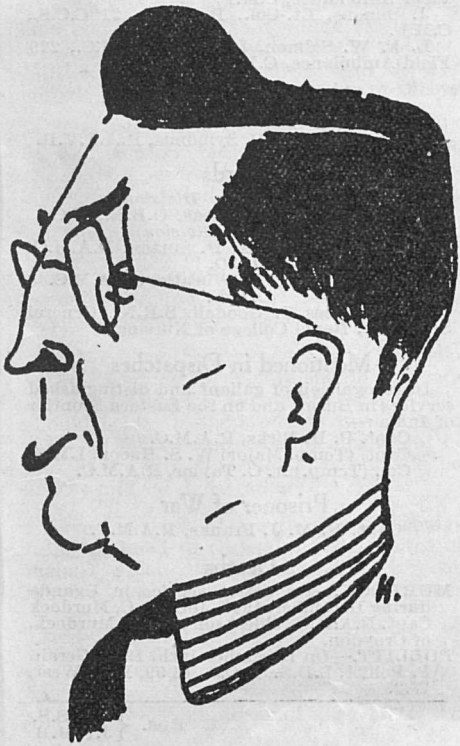
SIR,—At the last meeting of the Guy's Hospital Clubs' Union Council the application of the Guy's Hospital Students' Union for affiliation to the Clubs' Union was unanimously approved.

It is hoped that the Guy's Hospital Students' Union will foster the welfare of the Students and provide a means of expressing student opinion, professional and otherwise, excluding political opinion.

The Secretary of the Guy's Hospital Students' Union is Mr. B. D. Grant.

Yours, etc.,
F. R. KILPATRICK,
Hon. Secretary,
Guy's Hospital Clubs' Union.

Nuffield House,
Guy's Hospital, S.E.1.



Association

GUY'S *v.* READING UNIVERSITY.

(*Played at H.O.P. on Saturday, January 8th.*)

This match resulted in a win for Guy's by 5 goals to 1, thus maintaining the XI's unbeaten record to date this season with 97 goals scored for and 19 against.

This was an enjoyable game played under ideal conditions ; the defence played steadily throughout and made good use of their heads. The forwards, however, although there was some spectacular shooting, particularly by R. Finney and M. J. L. Sykes, did not play sufficiently well together ; the inside forwards tended to bunch in the centre and passes were made too late.

At the change over Guy's were leading by two goals to nil, having scored through M. J. L. Sykes and C. B. Clarke. Guy's then soon increased their lead through Finney, who managed to score after hitting the upright and cross bar with consecutive shots. Finney scored again with a fine drive following a centre from the right wing. Reading then made their only dangerous attack on Guy's goal and were rewarded by scoring. Ten minutes from time Finney scored the fifth goal by heading in a well-placed corner kick by R. Owen.

Team.—A. E. Triste ; E. G. Murphy, T. McNeil ; C. S. Matthews (captain), R. D. Rogers, S. Stableford ; R. Owen, R. Finney, C. B. Clarke, M. J. L. Sykes, F. R. M. Young.

Sport

Rugby

GUY'S *v.* BEDFORD R.F.C.

(*Played at Bedford on January 8th.*)

Guy's, 11 points; Bedford, 14 points.

Vidot failed to appear for the start of this game, but, fortunately, the timely appearance of Kilby saved us the distress of taking the field one short. He is the captain of our Tunbridge Wells side and he scrummaged very well in his first game for the Hospital.

Guy's quickly opened the scoring through Boyd, who ran strongly after a good three-quarter movement in which Strathie paved the way for his try. This was soon followed by a Bedford try initiated by two of their forwards, who were allowed to break away from a line-out. We then presented our opponents with a penalty goal by getting offside in front of our own posts. This is a regrettable habit which has lost us more than one match this season.

Until half-time play continued very evenly, but Bedford scored again and A. C. Macrae-Gibson injured his ankle, having to leave the field. Later he returned, but could barely run, though this did not prevent him from tackling with his customary vigour.

With the wind and slope in our favour and some delightfully long touch-kicking by Strathie, we spent the greater part of the second half near our opponents' goal line, but for a long while just failed to cross it. Our movements lacked the polish which makes the difference between a score and a near miss. However, a quick heel from a set scrum enabled Willcock to score a brilliant try by side-stepping six men and grounding the ball under the posts. Ten minutes later he repeated the performance to the delight of a large crowd, scoring on the blind side this time and making the score 11 all. Gullick's long goal kick fell just beneath the cross-bar.

Play was very exciting now, but another break was necessary when Hildick-Smith was knocked out and had to be carried off. He had not made a mistake and we were very sorry to see him go, but decided to do without a full-back in an effort to score once more. Bedford, exploiting our weakness here and on the wing, eventually scored in the corner just before time to win a most interesting and enjoyable game.

Team.—G. Hildick-Smith; A. C. Macrae-Gibson, N. K. Macrae-Gibson, D. M. Strathie, D. C. Boyd; E. W. Graham, R. D. Willcock; A. Batty-Shaw, A. B. Lee, R. A. Dean, D. Gullick, J. Kilby, S. M. Hilton, C. Zier-vogel, R. G. L. Brittain.

Hospital Information, etc.

Notices

On the return of the School from Tunbridge Wells there is likely to be a great shortage of suitable lodgings within easy access of Guy's. It is hoped that old Guy's men and any parents of present students may help in this matter. Should they find it convenient to board any of the returning students they should communicate with Mrs. Moore, University of London Lodgings Bureau, 15, Golden Square, W.C.2.

Pass List

UNIVERSITY OF OXFORD

D.M.

December, 1943.

P. M. F. Bishop, B.M., B.Ch. (Oxon).

UNIVERSITY OF LONDON.

M.D. EXAMINATION.

December, 1943.

L. P. R. Fourman.

Appointments

Dr. Geoffrey Marshall, O.B.E., F.R.C.P. has accepted the invitation of Sir Walter Womersley to act as honorary consulting physician to the Ministry of Pensions.

Change of Address

T. D. Birtwhistle, Surg.-Lt. (D.), R.N.V.R., H.M.S. *Royal Arthur*, c/o G.P.O.

P. H. Denton, S/Ldr. R.A.F., A 4134, R.A.F., c/o A.P.O. 5885.

Oliver Ive, M.R.C.S., L.R.C.P., 1, Rotherwick Road, Golders Green, N.W.11 and 121, Harley Street, W.1. *Tel.*: Speedwell 3347 and Welbeck 6818.

A. B. Kettle, Capt., R.A.M.C., 246763—4 C.C.S., C.M.F.

K. W. N. Palmer, Major, R.A.M.C., Headquarters Medical 38th (W) Division, Home Forces.

D. W. Lloyd, Lt.-Col., R.A.M.C., 159 (W) Field Ambulance, C.M.F.

J. Simons, Lt.-Col., R.A.M.C., 21 C.C.S., C.M.F.

L. F. W. Salmon, Lt.-Col., R.A.M.C., 220 Field Ambulance, C.M.F.

New Year's Honours

C.B. (*Military Division*).

Air-Commodore C. P. Symonds, R.A.F.V.R.

Awards

C.B.E. (*Military Division*).

Col. (Temp.) R. H. Lucas, O.B.E., M.C.

O.B.E. (*Military Division*).

Col. (Temp.) W. H. A. D. Sutton, R.A.M.C.

D.S.O.

Temp. Lt.-Col. P. R. Wheatley, R.A.M.C.

O.B.E.

Miss Frances G. Goodall, S.R.N., General Secretary, Royal College of Nursing.

Mentioned in Dispatches

In recognition of gallant and distinguished services in Burma and on the Eastern Frontier of India:—

Capt. P. H. Birks, R.A.M.C.

Capt. (Temp. Major) W. S. Hacon, I.M.S.

Col. (Temp.) A. C. Taylor, R.A.M.C.

Prisoner of War

Capt. R. M. J. Franks, R.A.M.C.

Deaths

MURDOCK.—On active service in Uganda during December, 1943, John B. C. Murdock Capt. R.A.M.C., eldest son of John Murdock, of Croydon.

POLLITT.—On December 15th, 1943, Gerald P. Pollitt, L.D.S., R.C.S., of 99, Park West, W.2.

EDS. {D.R.S.S. J.P.M.B

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVIII. No. 1449 *5th February, 1944* *Ninepence*

PASSIM

DO you remember the stir that the publication of the Beveridge Report made when it was published? It was the universal topic of conversation from the House of Commons to the music-hall stage. And yet, like a freshening breath of air on a sultry night, it seems to have died already. The Report caught the emotions of the people who appear to have forgotten it so soon, partly because the moment chosen for its publication was psychologically bad. But we do not intend to speak of the Report; we merely wish to draw a lesson from the decline of interest in the Report and apply it to our own smaller sphere of Medicine—namely, that of Social Medicine, which does not mean, as so many think, Socialist Medicine, but Medicine contemplated in the light of the individual or communal environment.

The idea of Social Medicine does not seem to have "caught on" amongst doctors and students, partly because the term has a political ring about it. This is unfortunate; perhaps a better name would be Ecological Medicine, which is more scientific. However, it is difficult to believe that antipathy can be overcome by simply changing a name. This indifference to the possibilities of this approach to medical problems is in some way comparable to that which existed in the times of Pasteur, Simpson and Koch, when they laid their discoveries at the feet of mankind. There was no vision of possibilities, but we who follow honour these men and their disciples, reaping where they sowed. Can we not say the same of this new science, Social (or Ecological) Medicine?

The drugs that this new approach will prescribe will probably prove unpalatable. It may consider radical operations on cancers of society to be a necessity for which the patient cannot see the need. Some measures may be only temporary and, again, some may fail, but what the patient will dislike will be the means, not the end.

Turning from the general to the immediately particular, what part are we at Guy's to play? We fell in with Pasteur, Koch and Simpson a hundred years or so ago. Surely we cannot minimise the importance of the subject when one of our teachers occupies the first chair of Social Medicine in this country and has already instituted teaching along these lines for Oxford medical students.

We realise the impossibility of immediate action, but as soon as conditions permit we feel that arrangements should be made here for teaching such as Professor Ryle gives at Oxford. We should know how the almoner's department works; arrangements should be made for students to accompany the Hospital health visitors; visits be made to factories where some idea might be gained of industrial accidents and fatigue; and, above all, greater emphasis should be laid on the whole environmental factor in all the clinical departments.

We feel that only with this knowledge may we consider ourselves to be doctors, fully qualified to understand the source of all the ills physical, mental and environmental which afflict mankind. However, discussion of these factors factors is too involved and debatable subject for a Students' editorial.

Professor Ryle wrote in "Passim" of the *Gazette* for August 17th, 1912, these words: "Heredity and environment are the two great enemies and the two great allies of social progress and national hygiene, and it is only in so far as we are able to improve environment and call heredity to our aid that we become capable of making noteworthy advances." Time does not alter facts.

Minor Surgery

By N. L. ECKHOFF, M.S., F.R.C.S., *Surgeon, Guy's Hospital.*

A Lecture delivered at Guy's Hospital Medical School, on December 9th, 1943.

GENTLEMEN,—This lecture is by request—that is to say, somebody suggested that I should talk to you about minor surgery, and I am very grateful for the suggestion, because, when thinking of a suitable title for a clinical lecture, one always wonders whether the subject chosen will be one about which students already know too much, or, perhaps, about which they do not need to know anything at all.

There seems to be a general desire that I should talk to you about minor surgery. I was rather surprised to discover that a certain number of dressers seemed to be entirely unaware of their real responsibilities or duties. I have never felt that it was my job to tell them their duties, as these are things which one usually picks up at Guy's in an automatic way. But the position of a dresser at Guy's in particular depends on the firm spirit, not very much in evidence during the War, unfortunately. A firm consists of surgeon, assistant surgeon, registrar, house surgeons, dressers and ward clerks. The activities of the firm are best demonstrated during the " take-in " week, when the whole firm, with certain selected dressers and clerks, are deputed to be on duty for that week. It is the business of the dressers to keep in touch with the house surgeon, make themselves acquainted with all that is going on, and take under their own personal care the cases as they come in. During that time the dresser must always be available ; he must be on the telephone in the hospital and be ready to work at any time.

These same duties are carried out when the firm is not taking in. The dressers have to make themselves responsible for cases as they are admitted. Each dresser must realise that it is his duty to do this. It is his first test, maybe, in real responsibility in relation to a patient. My dressers often come to me in the operating theatre and say : " Do you want me to wash up for this case ? " My answer is usually not printable. The position is that it is the dresser's privilege to wash up for the case for which he is responsible, and he should get on with it. Sometimes I find that I have got ready, and so has the house surgeon, but the dresser is still smoking outside.

It is also very important that he should busy himself with the writing up of cases in Out-patients' in order to save the surgeon trouble and to teach himself a lot. It is only by the consistent writing up of cases that one begins to realise what matters and what does not. It is very easy to forget what was said a fortnight previously. Therefore, whenever you see a patient, make suitable notes.

Dressings.—There are a certain number of cases operated on every week that, for want of a better term, we call " clean stitch " cases. I need not quote examples ; you know exactly what I mean. In those cases the wound is sutured at the time of operation, and there is very little treatment required. It seems quite difficult to infect a wound that has been properly sutured, so much so that some surgeons do not put on any dressing at all. We consistently leave facial wounds exposed to the air from the very moment of operation.

But although it is difficult to infect such a wound you must take every precaution when removing the stitches. I well remember a patient upon whom I operated, afterwards allowing her to go home. She came back again with a wound which appeared quite dreadful. A doctor had been asked to remove the stitches. He had—to quote the account given—opened his little black bag and taken out an instrument and removed the stiches. Forty-eight hours afterwards she had a high temperature and streptococcal septicæmia. On his second visit the doctor sterilised his instruments before examining the wound, and thereby gave himself away. That was in the days before we had sulphanilamide, and that patient died of streptococcal septicæmia.

In these " clean stitch " cases there is no necessity to look at the wound at all until the removal of the stitches. In wounds of the face and neck it is customary to remove the stiches by the fourth day, and we find that quite satisfactory healing has occurred by that time. We remove the stitches deliberately so that no scarring will be left from the stitches themselves. A simple sutured wound will heal with a nice fine scar, but

if you add the little marks of the stitches it becomes visible and ugly. Therefore remove stitches early to avoid those little marks.

From what has been said it might be supposed that it is in order to remove stitches from an abdominal wound at an equally early time. I think one could do so, but it has always gone down in surgery that the stitches should remain in an abdominal wound for ten days, and one feels it a little dangerous to remove them on the fourth. I remove the stitches in simple appendicectomies and hernias in seven days, usually leaving mid-line abdominal stitches in for ten. In people suffering from malignant disease I prefer to leave the stitches in for fourteen days because those people seem to burst the abdomen remarkably easily. I do not want to spend time in talking about suture materials. I feel sure that silk as a suture material is much more reliable than catgut, and burst abdomens would be rarer still if we gave up using catgut altogether.

Drainage.—There are various operations for which we use drainage as a routine, such as operations upon the gall-bladder and breast, etc. In others drainage is in debate—operations for acute appendicitis, perforation of gastric or duodenal ulcer, etc. Recent figures show that patients who have acute appendicitis are less likely to have post-operative complications if no drainage material is used. The supporters of this view say that the mortality is less. Drainage of the peritoneal cavity at once produces the circumstances which make for adhesions in the abdomen afterwards, with the attendant dangers. But the desirability or otherwise of inserting a drain in acute peritonitis is a thing which you must leave to the surgeon for the time being.

Drains inserted in the abdominal cavity should be removed early. Shorten the drain at the end of thirty-six hours and remove it completely in forty-eight. You must, of course, distinguish at once between drains which are placed free in the peritoneum and tubes inserted into a hollow viscus. A tube placed in the common bile duct usually remains there ten days. In a hollow viscus like the stomach it is left in place for much longer ; it may be for months, it may be for ever.

To return to cases where the tube is placed to allow serum to escape—not pus—cases which also are extra-peritoneal—you can safely leave the tube in position for a longer period. One so often sees the tube removed on the second day and a collection of serum making itself evident on the third or fourth. It is wiser to leave the tube in in these cases until the discharge of serum is minimal. There are certain special cases where the tube has to be left in for a longer period. You may be asked how long to leave the tube in a patient who has an empyema. The answer is that you leave the tube in as long as he has the empyema—*i.e.*, until the empyema cavity ceases to exist. This is, of course, checked by repeated X-ray examinations with lipiodol or some similar contrast medium.

Limb Wounds.—Nowadays the tendency is to treat a limb wound in such a way as to convert it into a saucer-shaped cavity. If that is done there is no need for drainage material in the ordinary sense of the term. Vaseline gauze is packed in lightly, and this is gradually extruded by the patient automatically as the wound heals from the bottom.

Wound Lavage.—The desirability of " washing out " deep wounds is debatable. The introduction of rubber tubes, syringes and chemical solutions carries with it the risk of secondary infection, whilst the irrigating fluid can do little more than wash away secretions from the surface. Granulations are desirable in bringing about healing from the bottom. In the case of surface wounds, however, granulations are undesirable, as they inhibit epithelial growth. Here immersion of the patient in a bath, along with other measures, is useful in reducing the bacterial flora and the granulations, and so assists epithelial growth—with or without grafts. Remember that suitable grafting can greatly cut short the period of healing.

Antiseptics.—You will want to know something about antiseptics. Remember, first, that it is probably impossible to sterilise the skin, much less a raw surface, but antiseptics can help in reducing the bacterial flora.

The classical experiments of Lister were performed with carbolic acid (phenol). Lysol (a phenol derivative) is used to-day. Strong solutions will kill human tissues, while weak solutions, if absorbed may induce toxic changes. The difficulty is to find a solution strong enough to kill bacteria without damaging tissue cells. The same is true of the iodine group, and severe reactions may occur. Alcohol is credited with

antiseptic properties, but coagulates protein. It is not used on raw surfaces—and is not entirely reliable for instruments. It is convenient for cleansing the skin owing to its drying properties, and is used freely in antiseptic solutions. Chlorine is made use of as sodium hypochlorite, an important constituent in Eusol and Dakin's Solution. Oxygen is the agent in potassium permanganate and in hydrogen peroxide.

Flavines (acri-, eu- and pro-) were extensively used in the last war and are to some extent coming into use again. They are credited with high antiseptic properties and may be left in cavities, though recent reports indicate that they may produce sloughing if packed in.

Aniline dyes (methyl violet or crystal violet, etc.) have an affinity for gram positive organisms and have been used extensively. Bonney's blue contains crystal violet and brilliant green, and is said to be an excellent skin antiseptic. Acriflavine added to this makes triple dye which has been used extensively for burns.

Most of these substances have their advantages and disadvantages, and have been popular and unpopular in turn. To day the sulphonamides hold the field and, used locally, can very often get rid of streptococci. But they also fail at times and sometimes produce reactions. Propamidine may succeed where the sulphonamides fail, and penicillin promises to be able to deal with staphylococci. It is too early to know of its limitations.

Remember once again that it appears to be impossible to sterilise a skin or raw surface, and that anything that will kill organisms is likely to have some undesirable effect upon human tissues.

If what I have said about antiseptics is true, it is clear that whether or not you use them in dressings does not seem to matter a great deal, but, with the exception of the last few, what matters is that you should keep the wound clean in the ordinary common-sense use of the term ; this cleansing can be effected by washing the wound with almost any solution preferred. Nowadays we use very often a new solution C.T.A.B., which is very useful as a detergent for cleansing surfaces. But we also use simple saline in a bath, plunging the patient in the bath and letting the saline run over him. Apart from its use in burns and large raw surfaces, baths are used after operations on the anus and perinæum, and any parts of the body which it is difficult to keep clean.

How long are you to go on applying substances to a wound ? You must keep the wound clean by regular and frequent washing ; you may or may not decide to use bacteriostatic agents, but you only cease treatment when the wound is healed. If a wound does not heal in the time that experience has taught you to be usual there is probably some underlying reason, such as the presence of a foreign body or a bit of dead bone or excessive movement, which must be investigated and eliminated.

I hope I have given you a fairly satisfactory answer to the problem of how to dress wounds, but it is a difficult subject to handle in the abstract. It is much more easy to talk about cases as they arise, and there you have to be guided very largely by the house surgeons, the registrars, and the ward sisters. It is not for me to say that you should receive instruction from the ward sisters, but if you ask them in the right way you can derive a great deal of information from them. Use masks for all dressings.

Minor Operations.—It is difficult to know which operations may justly be called minor. No operation should be treated as a triviality, and a lighthearted attitude is only too strongly to be deprecated. The greatest tragedies can emerge from operations which appear to be minor. I know of patients who have died after circumcision or removal of sebaceous cysts or similar apparently trivial procedures. The greatest care in asepsis, and, once more, the use of a mask in carrying out any operation of whatever magnitude is absolutely essential. I need not tell you in great detail how to prepare yourselves for the operation. You know it means scrubbing the hands up to the elbows and keeping the finger-nails clean and short. The scrubbing should be carried out very thoroughly for the first operation of the day, but if it is overdone between operations the hands may be made sodden and moist and cracked, which will be conducive to infection rather than the reverse.

Bear in mind also that it is extremely difficult to get the right atmosphere of asepsis in other places than the operating theatre. For some reason, when the operation is carried out in a room which does not happen to be the operating theatre, the atmosphere

is missing. The nursing staff cannot be persuaded to regard the procedure with the same seriousness. It is a defect I find it impossible to overcome.

Circumcision.—There are various methods used for circumcision, but having seen it carried out by a rabbi I have decided that the simplest method is the one he uses. Perhaps you do not know how it is done. The rabbi uses an instrument rather like that which the soldier has to clean his buttons. This he puts over the front of the glans after stretching out the excessive amount of prepuce which is cut off. He is then presented with two layers of divided prepuce. The hole in the centre being a good deal smaller than the glans itself, he uses his thumbnails to stretch that opening and push the skin back. He puts a dressing round the wound and leaves it at that. He does not seem to be very much concerned about the matter of hæmorrhage, but occasionally it gives trouble and for that reason I would prefer to use an operation rather like his, but modified in one small detail. Instead of using the instrument which I have described, I prefer to use a pair of bone-cutting forceps, with the bevel towards the glans. One crushes along the line and cuts off the excess. It is then necessary to find the central hole, stretch and push the skin back. It leaves more of the inner skin than in other operations for circumcision, but it is remarkable how in time this contracts and a useful result is brought about. Frankly, this is the operation I would advise you to choose. The more common operation involves trimming off the excess of inside skin and suturing round the edges. This is a finicking business, which takes much longer and may give rise to trouble from bleeding.

Another operation is to start with a dorsal slit. The triangular flaps produced are turned back and cut off, and hæmorrhage is dealt with. This, again, can cause unpleasant bleeding.

Sebaceous Cysts.—Here, again, I propose to be somewhat unorthodox. When you are presented with a sebaceous cyst it is the wish of your heart to dissect it out, and in consequence you make an incision over the cyst and proceed to dissect the flaps each way and remove the cyst whole and complete. The following method is quicker and just as satisfactory. An incision is made right through the cyst from front to back with the first sweep of the knife. You then have two halves like a split pea, and each of these is seized with a pair of Spencer-Wells forceps and pulled out. The whole operation is completed in a matter of seconds. This operation cannot be carried out when the cyst is infected, but under those circumstances you would not think of dissecting it out. All you can hope to do is to incise and provide drainage, leaving excision to a later date.

If the cyst is large it will be necessary to excise an ellipse of skin.

The Toe-nail.—The problem of the toe-nail causes a good deal of worry. You have all seen cases of hypertrophy of the toe-nail called onychogryphosis. In these it is satisfactory to remove the toe-nail by avulsion, but it will grow again, and it will always be deformed. The patient's discomfort can be shortened by an operation for complete removal of the nail-bed. Other cases which are worrying are young people who get an ingrowing toe-nail. As a general rule the condition occurs in the young, which hints at the ætiology—the rapid growth of the foot with unequal development in the footwear. Short socks are a prominent cause. It occurs oftener in people who have excessively long first toes. In most people the big toe is longer than the second. The pain and trouble start on the medial side as a rule, which again implies that pressure is the cause. Some people seem to have nails shaped in such a way as to make ingrowth, as it is called, more easy. Their nails, instead of being of a nice gentle curve, are rather highly arched.

Pain and inflammation start on the medial side and in a very short time infection occurs. The skin at that point becomes hypertrophic and tends to overgrow the nail which makes the symptoms worse. In the acute phase it is quite legitimate to remove the nail by avulsion, which means that you plunge a pair of artery forceps or other special forceps right down the middle of the nail, and rock it first one way and then the other until it comes off. The nail will certainly grow again and may present you with the same problem again, whilst patients get very tired of having their nails pulled off about once a year. Therefore, warn the patient against short shoes and socks, advise him to keep the part dry (for these people often have rather sweaty feet), and allow the nail to grow in a straight and decent manner. It is usually advised that the nails be allowed to grow perfectly straight with no trimming at the corners. Sometimes you can break the back of the nail by paring it down the centre with a broken piece of glass, gradually scraping away some of the nail until it gives at that point. A file can

be used if preferred. It is also useful to insert a tiny piece of cotton-wool between the nail and the skin. Strangely enough, however, I suggest to you that this orthodox handling of the problem is not always successful. I find that in a great many people it is essential to cut away the corner of the nail from time to time to relieve the condition You must decide in individual cases whether you will tell the patient to let the nail grow straight or cut it down in the corner, but I have found that proper cleanliness and attention to the nail in the corner does relieve the symptoms.

Complete removal of the nail-bed is done by making an incision in the mid-line of the toe, curving round the back edges of the nail and turning back the flaps thus produced. This exposes the nail-bed. The nail is avulsed and the nail-bed cut away with a very small knife and pared down until it no longer exists. This should guarantee that the nail will not grow again. Some people are a little frightened of their skill in paring away the nail-bed and prefer to do a partial amputation of the last phalanx. This is quite legitimate and satisfactory. It shortens the whole toe by a quarter of an inch, which does not really matter. It is done by a transfixing incision on the plantar side of the bone after going through the distal phalangeal joint, turning back the flap thus created.

Tapping Hydroceles.—The old-fashioned method of getting the patient up against the wall is all very well, but the patient is apt to fall down on top of you. If you make the patient lie on the couch he is quite equally at your mercy, and cannot escape through the floor, and you can do the operation nicely. Never do any operation without the patient lying down. The more people boast of their endurance, the more likely they are to collapse. The testicle is situated behind on the medial side and you push your needle in in front. There is no need for a large trocar.

Injection of Varicose Veins.—To-day ethamolin is probably the best of all solutions to use. It is wise to ligate the veins at the upper end when the valves are incompetent. Ligation must include all the tributaries.

Vein Puncture.—I wanted to tell you a little about putting needles into veins generally. Always have the vein as dilated as possible. In the case of varicose veins this is done by keeping the leg in a dependent position. It may require a venous tourniquet. Always make sure that you are in the vein. Unless the blood flows back easily along the needle into the syringe you must not in any circumstances inject. Some people find it simplest to place the bevel of the needle flat on the skin and some prefer the other way, with the bevel facing upwards, with one plunge going right through the vein and withdrawing the needle slowly until blood appears in the syringe.

These are personal matters, but it does lead us on to infusions in general. If you are to give only one bottle of fluid it is satisfactory to push a needle into the vein and leave it at that, but with continuous infusion it is wiser to do a deliberate operation cutting down with the insertion of a cannula. It is extremely important that complete asepsis should be preserved, because with a cannula in the vein for several days there is a risk of unpleasant phlebitis unless every possible precaution is taken. An incision is made at right-angles to the vein. Having exposed the vein a piece of ligature material is tied at the distal end. That is used to control the flow in the vein and also as a tractor, so that the vein is lifted into the wound. A second ligature is passed and tied loosely, and sharp scissors are used to cut a V-shaped notch into the vein. Blood will immediately appear, the cannula is inserted and the ligature tied. The exact method of dealing with the skin is of secondary importance as long as it is neatly sutured.

Infected Fingers.—I imagine that as dressers you will not be called upon to operate on these. Remember that the incision must be on the lateral side, and never under any circumstances on the volar surface. Most horrible scarring results if you make incisions on that aspect. The incision must be adequate. The operation must be done under a tourniquet and if the incision is correctly made there is no need to dress the patient for several days. In fact, we are nowadays making an incision and encasing these fingers in plaster-of-paris, after putting a little vaseline gauze in the wound, and leaving them alone for a week. That method of covering them up for a week, assisted by elevation of the limb as a whole, leads to a most remarkable and rapid improvement in the finger.

If the incision is correctly placed and adequate, drainage should not be necessary for more than a short time. The period for which it is necessary will be dictated much better by the patient than by the dresser. So, once again, for infected fingers make the incision in the right place, put in a vaseline gauze drain, cover the finger completely and elevate the limb.

Obituary

K. S. KEELE.

EACH year at Guy's usually has its outstanding figure—a man of his year who stands out amongst his fellows because of his all-round excellence. Such was Keith Keele in his time. The secret of his prominence lay partly in his own character and partly in his superior skill which crowned a wise education.

The period immediately following the first World War brought into dental surgery, as in all other careers, men of different types with wide experiences of life, but without a background of dental practice. They took to dental surgery fresh vigour and broadened the outlook of their fellow-students who were sons of the profession. Keith Keele appealed to both types. He had grown up in that excellent dental practice of his father, also a Guy's man, but before embarking on his dental and medical studies he spent four years at Oxford. At Wadham College, where he was an exhibitioner, he read Hon. Mods. and Greats, and took his degree in 1918. The pure classics appealed to him more than the history or philosophy, but a favourite quotation of his was from Herodotus :—"I shall go forward with my history, describing equally the greater and the lesser cities." If his culture attracted the older men and his dental experience the younger, it was his innate modesty and charm which made friendship with both natural.

At Oxford he rowed for his college, and he was one of the stalwarts of the Boat Club at Guy's. His skill at dental surgery won him the Operative Prize. He took his dental qualification in 1926 and his medical in 1929. Then followed a period as dental demonstrator from 1927 to 1935, when he never grudged his skill and knowledge, but gave many dressers an interest and grasp of conservative dental surgery by his own infectious thoroughness. Within a short period his health gave up and he was forced to retire from practice, going to live in the Lowlands of Scotland with his wife and two sons. And now at the tragically early age of forty-three he has left us. But his influence on those who knew him has not gone. Many will feel that they owe him a debt which can only be repaid by keeping up the high standard of workmanship which his example inspired.

Clinical Pathology Meeting

ON January 28th and 29th, 1944, Guy's was privileged to welcome the Association of Clinical Pathologists, who held their seventeenth Annual Meeting in the Medical School. Both mornings were devoted to communications read in the Anatomy Theatre and, after lunch in the Wills Library, the members showed a variety of demonstrations in the Bacteriological Department. The dinner on Friday evening was held at Brown's Hotel. Dr. A. F. S. Sladden, Director of the Beck Laboratory, General Hospital, Swansea, in his Presidential Address on "The Significance of the Laboratory," gave an admirably balanced review of the future scope of this branch of medicine in relation to coming reconstructions and an excellent programme arranged by the hon. secretary, Dr. W. H. McMenemey, of the Royal Infirmary, Worcester, left no doubt in the visitors' minds that clinical pathology is by no means the least important section of the subject as a whole. By invitation of the Association the chair was occupied by Professor Wright on the Friday and Dr. Knott on the Saturday. The first day's proceedings included an exceedingly valuable review of the types of encephalitis met with in children, illustrated by a demonstration of some first-class sections. Dr. R. Gloyne summarised the histological problems met with in bronchial biopsy; and Dr. H. S. Baar did the same as regards fibrocystic disease of the pancreas. The thorny question of relative accuracy in hæmoglobin estimation was amusingly touched upon by Dr. R. G. MacFarlane, using the older Haldane-Gowers instrument, with which the personal equation can clearly introduce most startling variations; and by Dr. P. Kidd, using the one-celled photometer, delightful in its mechanism, but costly in space. Professor R. A. Peters discussed the value of blood pyruvic acid in clinical work; Dr. C. Rimington did likewise concerning porphyrin estimation; and Dr. I. R. Morris described new work on blood volume estimation. For those, and they are not rare, who find difficulties in the histological differentiation of the various glandular hypertrophies, there was great interest in a beautiful demonstration of the laboratory findings

in lymphoid follicular reticulosis by Dr. A. H. T. Robb-Smith. Communications also came from Dr. J. L. D'Silva on ascorbic acid saturation tests; from Lieut.-Col. R. F Bridges on the improved methods in the identification of dysentery bacilli; and from Dr. A. Q. Wells on the close correspondence between the findings of mass radiography and direct laboratory observation in cases of early tuberculosis. The contributors from Guy's were Dr. Keith Simpson, who opened an attractive discussion on the trivial causes of sudden death so easily overlooked at autopsy; Dr. P. A. Gorer, who demonstrated films of a number of unusual leukæmias in man and also several which by artificial means he had succeeded in provoking in mice; and Dr. F. A. Knott, who, by comparing two successive years, showed the markedly reduced incidence of sepsis in the maternity department if invasive staphylococci were excluded. In the first year only late exclusion of septic cases took place and the second, all staff and patients underwent routine bacteriological examination before admission. Specimens of great interest were shown by members from many parts of the country including Dr. Whittle (Cambridge), Dr. Hocking (Truro), Dr. F. B. Smith (Preston), Dr. Delikat (Wolverhampton) and many others; the representation being, in fact, country-wide.

The attendance was large throughout the meeting, the Anatomy Theatre being often filled to capacity, and it added to the general pleasure that Guy's had been chosen as this year's meeting place of the Association to see at various stages of the proceedings such welcome visitors as Sir H. Letheby Tidy, Air-Marshal Sir H. Whittingham, Air Commodore Morton, Dr. Geoffrey Evans, members of the Turkish Medical Mission to England and a considerable number of officers of the American Forces.

Correspondence

GUY'S HOSPITAL SAILING CLUB.

To the Editor of the GAZETTE.

SIR,—Little if anything has been published of the activities of the Sailing Club since the War began, at least to my knowledge. Therefore I decided not only to give notice of the forthcoming general meeting, but also a brief account of the Club's activities during the last year and its plans for 1944.

In 1943 its membership was eighteen, but only about one-half of this number ever sailed. Apart from the casual sailing which was so pleasant during the summer, races were also held by the London Corinthian Sailing Club (to whom we are so greatly indebted for the use of their premises for the duration), in which members took part. In these handicap events several members from this Hospital carried off places—notably Lowein, Reid and Elphicke. Facilities were provided and used for the instruction of several new members. This year I have arranged (as Hon. Racing Secretary of the United Hospitals' Sailing Club) a season of inter-hospital sailing matches. This will be something of an experiment, as there have been no such races since the outbreak of hostilities, whilst we have been sailing on the Thames. I hope that this will stimulate a little more interest in the Sailing Club, and that the reports of the sailing matches in which Guy's takes part will be read with as much fervour as the rugger or hockey announcements.

The date of the annual meeting is not yet fixed, but notices will shortly be put up on the notice-board in the Colonnade and in the Medical School. Anyone who wishes to sail with the Club in 1944 should attend, as full details of the facilities for sailing and plans for the year will be discussed as well as other matters.

It may be necessary to limit the membership, in which case preference will be given to people residing in the London area and who are already proficient in the art of sailing.

Yours, etc.,

D. J. REID,

Hon. Secretary, Guy's Hospital Sailing Club.

ÆTIOLOGY OF HYPEREMESIS.

To the Editor of the GAZETTE.

SIR,—When I read Sir Arthur Hurst's "The Hysterical Nature of So-called Pernicious Vomiting of Pregnancy" in the *Gazette* of October 16th, 1943, I felt that there was a touch of disappointment in his article—disappointment that he had failed to convert opinion as to the importance of the hysterical factor in hyperemesis gravidarum. I hasten to assure him that his teaching on this subject in the last twenty years, so far as its main practical bearing is concerned, has been almost universally accepted and acted upon. So far from being disappointed at the results of his influence, he should feel gratified at the widespread improvement in outlook and treatment that he has been able to effect. At the same time he should forgive those who are not yet satisfied to dismiss the whole difficult subject of the ætiology of hyperemesis by dubbing it "hysterical," even though hysteria may be a predominant factor. There is still no satisfactory explanation of the slight morning sickness of normal pregnancy, and to say that it is "physiological" is not in any way to explain its mechanism.

Sir Arthur has misinterpreted the views which I have expressed on this subject in the 1943 edition of my "Short Text-Book." He says that I now teach that cases of "hyperemesis in which Korsakow's syndrome of peripheral neuritis with mental symptoms develop are toxic in origin, because of the resemblance of the clinical picture and pathological findings to those produced by alcohol." I am unaware that I have ever taught such heresy. I have carefully re-read the forty-one pages devoted to the "toxæmias of pregnancy" in the 1943 edition of my book, and nowhere is there any suggestion that I regard the occurrence of Korsakow's syndrome complicating hyperemesis as evidence of a "toxic" basis for the disease. If Sir Arthur were to re-read those forty-one pages, I am confident that he would conclude that hypothetical "toxins" are anathema to me no less than to himself.

Yours, etc.,

G. F. GIBBERD.

North Africa,
November 27th, 1943.

LAMBRINUDI MEMORIAL FUND.

To the Editor of the GAZETTE.

SIR,—It is hoped that it will be possible to endow a triennial prize or scholarship in orthopædics with this fund, as it is felt that this would be the kind of memorial of which Mr. Lambrinudi would have most approved. In order to ensure an adequate sum a minimum of £1,000 is needed. We are now within sight of this goal, and it is felt that there may still be some of Mr. Lambrinudi's friends, old students and patients, who may not have heard of the fund and who would like to help us to reach our goal. Contributions should be sent to the appeal office and marked: Lambrinudi Memorial Fund.

Yours etc.,

T. T. STAMM.

"BOOKS FOR MALTA" FUND.

To the Editor of the GAZETTE.

SIR,—In a letter from the President of the B.M.S.A. we have been informed that Guy's Hospital Students' Union have collected for us the sum of £10 8*s.* 9*d.* as proceeds of a dance organised on behalf of the "Books for Malta" Fund. I have been directed by the President and members of the Council of the Malta Branch to thank you all heartily for the help extended at the time when our medical school was faced with alarming problems.

Now, at last, the times of distress have receded and, on looking back, we can appreciate all the more your effort in helping us when we stood in need.

With repeated thanks and best wishes for the future prosperity of your Union.

Yours, etc.,

GEORGE P. XUEREB,
Hon. Secretary.

B.M.S.A. (Malta Branch),
R. University of Malta Union,
220, St. Paul's Street,
Valletta, Malta.

Reviews

Handbook of Surgical Operations. By TREVES AND WAKELEY. Published by Cassell & Co., Ltd. *Price* 12*s.* 6*d.*

THE "Students' Handbook of Surgical Operations" now appears in its seventh edition. Revision has now changed the character of this book which caters for the student who wishes to read up surgical operations. The whole field of operative surgery is covered; thus a number of operations which a student never witnesses are included.

The section on amputations has been cut drastically to exclude all obsolete amputations. It is interesting to note that the author has fully described Syme's amputation.

This book should also be useful to those members of His Majesty's Forces who may occasionally be called on to perform an operation. F. R. K.

Sport

Rugby

GUY'S *v.* CAMBRIDGE UNIVERSITY.

Result: Cambridge University, 9 points; Guy's, 5 points.

The Hospital lost this game against Cambridge University by three unconverted tries to a goal. Alan Lee was playing for the Civil Defence and his place was taken by Kinder. The gap left by Strathie's departure for the Navy was filled by Derek Jones, a former captain of Llandovery; he has not played football for the last two seasons and, in his first game for the XV, made a promising début. Hildick-Smith and A. C. Macrae-Gibson were unfit; Edwards played on the wing and Westgate, from the "A" XV, at full-back. Westgate is a young player with a lot to learn about positional play, but on a very windy day he produced some very good right-footed kicks.

These changes in the side and a sandwich lunch on the train seemed to take the rip out of the Guy's team. The forwards did not play as a pack. Behind the scrum the backs appeared more skilful than the Cambridge line, but, without Strathie, seemed to lack thrust. Coutts, the Cambridge fly-half, made a good movement and sent Morton over the line to open the scoring. The University continued to press, and Davies, their full-back, joined in movement to score again. Both tries were unconverted.

After the interval Guy's saw more of the ball and, after several attempts to penetrate the defence, N. K. Macrae-Gibson scored an excellent try between the posts. Gullick converted this try. For the rest of the game the kicking of Sykes, the plucky Cambridge scrum half, was a feature of the game. Guy's could not add a winning try and, in the final minutes, Coutts consolidated the position for Cambridge by scoring between the posts.

Team.—S. F. A. Westgate; D. R. Edwards, N. K. Macrae-Gibson, D. Jones, D. C. Boyd; E. W. Graham, R. D. Willcock; A. Batty-Shaw, C. H. Kinder, R. A. Dean, I. H. Hilliam, D. Gullick, P. D. Harvey, C. Vidot, R. G. L. Brittain.

GUY'S *v.* LONDON HOSPITAL.

Result: Guy's, 14 points; London Hospital, 3 points.

The Hospital received a very kind welcome at Hale End from the London Hospital and enjoyed a pleasant if not very energetic game. Lee returned to the side, and Vidot, being ill, had his place taken by P. S. Carton-Kelly, of Downside and Oxford University. In his first game for the XV he initiated some good attacking movements and played a thoroughly reliable game. A feature of the match was the delightful play of the back division unchanged from the previous week. In the many movements which they initiated it would be hard to single out one person, but in Derek Jones it appears that Guy's have a player of promise.

Boyd played a very determined game on the wing and opened the scoring by crossing the line in the corner. Then followed a neat movement between Boyd and Jones, but the latter just failed to score. The London forwards powerfully led by Dew and Floyer, rushed to the Guy's line. Edwards, gathering a loose ball, ran strongly and passed for Graham to score between the posts. Gullick converted this try. Just before half-time Barnes scored an unconverted try for the London.

Willcock was concussed just before half-time and left the field. Playing seven forwards in the scrum Guy's heeled the ball regularly and further tries by Boyd and Ziervogel resulted. Neither of these were converted.

Team.—S. F. A. Westgate; D. R. Edwards, N. K. Macrae-Gibson, D. Jones, D. C. Boyd; E. W. Graham, R. D. Willcock,; A. Batty-Shaw, A. B. Lee, R. A. Dean, C. Ziervogel, D. Gullick, P. D. Harvey, P. S. Carton-Kelly, R. G. L. Brittain.

Association

GUY'S *v.* CAMBRIDGE UNIVERSITY.

(Played at Cambridge on Saturday, January 15th.

This match resulted in a win for Cambridge by 2 goals to 1. Guy's won the toss and decided to play with the sun behind them. For the first fifteen minutes Guy's pressed on the Cambridge goal and came very near to scoring on two occasions. Play soon became very even and Guy's were puzzled by the Cambridge mid-field play, at which their half-backs excelled themselves. Ten minutes from the change over Cambridge scored through their inside left following a dangerous attack on the Guy's goal.

During the second half Guy's definitely had the better of the game, but found the Cam-

bridge defence very sound, although a miskick by a Cambridge back on one occasion left their goal wide open; unfortunately the Guy's forwards missed this opportunity. After thirty minutes Guy's equalised through C. B. Clarke, who shot a spectacular and well-deserved goal.

The game now became considerably faster, dangerous attacks being made on both goals, one of which resulted in Cambridge scoring the winning goal five minutes from time. Guy's made a last attempt to equalise, when C. B. Clarke headed a centre from the right wing just over the cross bar.

Team.—A. Starte; E. G. Murphy, N. McNeil, C. S. Matthews (captain), R. D. Rogers, S. Stableford; R. Owen, R. Finney, C. B. Clarke, M. J. L. Sykes, F. R. M. Young.

London University League results:—

Saturday, January 22nd—*v.* Imperial College at Sudbury Hill. Guy's, 8 goals; Imperial College, 3 goals.

Saturday, January 29th.—*v.* Northampton Engineering College at H.O.P. Guy's, 17 goals; Northampton, 3 goals.

Hockey

GUY'S *v.* ST. BARTHOLOMEW'S.

(*Played at Chislehurst on January 29th.*)

Although Parry, our captain, and Parr were away from us playing for London University we were determined to beat Bart.'s on their home ground. We opened the scoring and both sides pressed hard in a very even game, with the score mounting up to 3–2 against us at half-time. The team continued to play well together, and Saunders was able to score his second goal, bringing the score to 3–3. Every effort was spent for the advantage of a goal lead. Guy's forwards were supported well by the halves and backs. Before the final whistle Burt had brought the score to 5–3 making it a well-deserved victory for Guy's.

Team.—H. W. Trusted, D. C. Dawson, B. H. Prideaux, K. W. Bolt, J. G. Richards, L. D. Carton-Kelly, G. Thompson, H. C. Jenkins, J. R. Burt, D. R. S. Saunders, G. R. Wotton.

INTER-HOSPITAL KNOCK-OUT TOURNAMENT

GUY'S *v.* WESTIMSTER HOSPITAL.
FIRST ROUND.
(*Played at H.O.P on January 15th.*)

The teams arrived at H.O.P. to find the ground obscured by thick fog, which suddenly lifted, enabling the match to be played. Our opponents were very keen, and at half-time we were one goal down. Soon after the whistle Burt gave us the equalising goal. An outstanding run by Saunders from our "twenty-five" just failed to score, but his efforts were rewarded a few minutes later. Another goal, each by Burt and Saunders, made the final score 4–1 to Guy's.

Team.—H. W. Trusted, D. C. Dawson, B. H. Prideaux, K. W. Bolt, J. G. Richards, L. D. Carton-Kelly, G. Thompson, T. C. L. Parry, J. R. Burt, D. R. S. Saunders, G. R. Wotton.

The Seven Ages of Doctors

All the world's a stage,
And all the doctors in it merely players;
They pass exams. and have obituaries,
And each one in his time plays many parts,
His life having seven stages. First biologist,
Swooning and puking at the sight of blood;
Then the anatomist, with his scalpel,
And fifth-hand Cunningham, watching the clock
And dozing on his stool. Then comes the ward clerk,
Filled with new zeal, and with well-writ reports
Made to his Registrar's eyebrow. Senior student,
Full of long names and theories obsolete,
Jealous in honour, sudden and quick in ward rounds,
Seeking the bubble of reputation
Even from his Surgeon's mouth. And then the H.S.,
Shocked by his lack of knowledge, good at bluff
With eyes severe and most sagacious tone,
All M. & B. and modern therapy,
And so he plays his part. The sixth age shifts
Into immaculate, best West End cut,
With thinning hair and sumptuous limousine,
Speaking of all the men he used to meet
When last out in the States. Last scene of all,
That ends this strange eventful history,
Is slicing golf-balls at the Wildernesse,
Cutting a quaint old figure on the course.

"WILL."

Hospital Information, etc.

Pass List

CONJOINT BOARD.
FINAL EXAMINATION.
January, 1944.

Surgery.

R. A. Allen	*N. L. M. MacManus
*A. Brown	D. J. Morton
J. Fry	T. C. L. Parry
*H. F. Hills	*C. L. E. H. Sharp
C. C. Kennedy	

Medicine.

*A. S. Carruthers	*H. F. Hills
S. Coffey	C. C. Kennedy
A. B. Dickie	J. L. F. Maine
*M. E. Evans	*J. K. Morgan
S. Freedman	A. B. Vanscolina

Midwifery.

M. A. Barker	J. V. Kent
*J. M. Fabricius	*J. Lorber
A. E. Gibbs	J. F. N. Sidebotham
M. V. Guilmant	*J. M. Thomas
*H. F. Hills	

Pathology.

R. G. L. Brittain	B. H. Pentney
G. J. Haas	S. Sheare
*H. F. Hills	*J. M. Thomas
J. C. Matthews	G. M. Turner
H. W. Palmer	G. R. Wotton

* Have completed the examination.

UNIVERSITY OF LONDON.

1ST EXAMINATION FOR MEDICAL DEGREES.

(For Internal Students.)

December, 1943.

R. J. Aspinall	J. Fine
D. S. G. M. Bailey	D. H. Griffiths
J. B. F. Boyle	A. J. N. Hage
G. Canty	G. E. Haward
P. R. Chalk	R. L. Leader
M. P. M. Coupland	D. S. Noble
D. B. Davies	R. J. Vale
A. K. Doust	R. D. Walsh
H. E. G. Dyer	J. D. Williams
I. I. Eckstein	

The following Higher School Candidates have completed exemption from the First Medical :—

E. Beswick	M. W. J. Grummitt
D. W. Clark	J. B. Harris
J. D. Derry	J. L. Herbert
J. C. Farrow	C. P. Mills
R. L. Gothilf	L. G. Richards

1ST EXAMINATION FOR MEDICAL DEGREES.

(For External Students.)

December, 1943.

A. E. McLauchlan	I. A. W. Scott
P. B. Poole	J. Vance

The following Higher School Candidates have completed exemption from the First Medical :—

C. N. Furnivall	D. F. N. Harrison

Papers by Guy's Men

Symonds, C. P. Response to Flying Stress. Foundations of Confidence. *Brit. Med. J.*, 1943, ii, 740.

Hurst, Sir Arthur. The Treatment of Sciatica. *Brit. Med. J.*, 1943, ii, 773.

Worster-Drought, C. Congenital Auditory Imperfection (Congenital Word-Deafness) and its Relation to Idioglossia and Allied Speech Defects. *Med. Pr.*, 1943, **210**, 411.

Hurst, Sir Arthur. Constipation. *Med. Pr.*, 1943, **210**, 375.

Lunn, H. F. The Regimental Treatment of Scabies. *J. Roy. Army Med. Corps*, 1943, **81**, 247.

Rushton, Martin A. Development of a Tooth in a Grafted Area. *Brit. Dent. J.*, 1943, **75**, 281.

Nancekievill, L., and Others. Sternal Puncture in the Diagnosis of Malaria. *Lancet*, 1943, ii, 468.

Rogerson, C. H., and Another. Paroxysmal Hyperinsulinism due to Islet Adenoma of the Pancreas. *Lancet*, 1943, ii, 479.

Symonds, C. P. Anxiety Neurosis in Combatants. *Lancet*, 1943, ii, 785.

Matthews, E. The Alginates in Dentistry. *Brit. Dent. J.*, 1943, **76**, 8.

Hurst, Sir Arthur. Nervous Diseases of Swallowing. Clin. J., 1944, **73**, 1.

Slesinger, E. G. Acute Appendicitis. *Clin. J.* 1944, **73**, 4.

Cohen, Sol M. Traumatic Arterial Spasm. *Lancet*, 1944, i, 1.

Bray, George. Nasal Allergy (excluding Hay Fever). *J. Laryngol. Otol.*, 1943, 58, 219.

Doherty, W. D. The Ætiology and Treatment of Urinary Calculi. *Practitioner*, 1943, 151, 341.

Awards

George Medal.

Flying-Officer Geoffrey Howard Dhenin R.A.F.V.R.

Mentioned in Dispatches

Brig. (Temp.) J. Walker, C.B.E., M.C., R.A.M.C.

Major (Temp. Lt.-Col.) T. McK. Robb, R.A.M.C.

Capt. F. M. Smith, M.C., R.A.M.C.

Change of Address

R. C. Green, Capt. A.D. Corps, 56 Dental Centre, P.A.I. Force.

Miss D. E. Thornton, P.M.R.A.F.N.S., No. 1 R.A.F. General Hospital, C.M.F.

Forthcoming Marriages

GOODHART—MORGAN. — On February 19th, 1944, the marriage will take place at St. Phillip's Church, Earl's Court Road, between Surg.Lieut. J. G. Goodhart and Margaret M. Eileen Morgan.

TAIT—HARDMAN.—On February 19th, 1944, at 11.30 a.m., the marriage will take place, at St. Martin's-in-the-Fields, between D. A. Tait and Jean M. Hardman. All friends welcome at the church.

Marriages

BREAKSPEAR—FISHER. — On January 1st, 1944, at Queen's Road Baptist Church, Coventry, Edgar Kenneth Breakspear, L.D.S., to Margaret Elizabeth Fisher, B.A.

Births

DE MIERRE.—On January 17th, 1944, at Southbank Nursing Home, Worcester, to Joan (née Davey), wife of Jack de Mierre, L.D.S., R.C.S. (Eng.)—a sister for Jeremy and Jennifer.

Deaths

FINCH.—On December 24th, 1943, Alexander Henry Finch, R.C.S., L.R.C.P., D.Ph., at The Shrubbery, Shepton Mallet.

HOLLAND-MARTIN.—On January 27th, 1944, suddenly, in London, Robert Martin Holland-Martin, C.B., of Overbury Court, Worcestershire (Governor of Guy's, 1917/44)

JEPHCOTT.—On 31st December, 1943, Charles Jephcott, M.B., B.Ch., of 37, Liverpool Road, Chester.

KEELE.—On December 30th, 1943, after many months of acute suffering most bravely borne, Keith Stephen Keele, M.R.C.S., L.R.C.P., L.D.S.(Eng.), M.A. (Oxon), of 4, South Lauder Road, Edinburgh, aged forty-three.

NESBITT.—On January 27th, 1944, suddenly, of heart failure, at 87, Cadogan Gardens, S.W.3, Robert Chancellor Nesbitt (Governor of Guy's 1934/44).

SEYMOUR-PRICE.—On January 24th, 1944, suddenly, at Comforts Orchard, Oxted, Surrey, Philip Seymour-Price, M.R.C.S., L.R.C.P.

VERNON.—On January 2nd, 1944, John J. D. Vernon, M.B., B.S., of Audley, Newcastle, Staffs.

WEBSTER.—On December 1st, 1943, Vivian Thomas Pearce, M.R.C.S., L.R.C.P., of Tygwyn, Merthyr Tydfil, Glam.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

IT must always come as a pang, as an inward blow to our pride, when a professional subject is broached by a layman on which we have no personal experience and, possibly, little even second-hand knowledge. Most difficult of all, one may own ignorance and immediately be subjected to the views expressed in the popular Press with all their dramatic garnishings. That is aggravating. Or one may attempt to bluff a way through, success increasing with practice and probably largely achieved by resort to obscure terminology and cynical mysticism, which, let it be known, is in reality rather more convincing to the medical man himself than to anyone else. So much has been said of the necessity of this ability to, frankly, fool the patient as a method of gaining his confidence that it becomes a plausible excuse for ignorance and haphazard methods—a situation rendered no better by recourse to the *cliché* that Medicine is an art and not a science. A world of Shaws would, to say the least, be a different place, but it would brook no such laxity. This trend of thought was provoked a few evenings ago when Colonel Schullinger, from the United States Army, read a paper at the Hospital, entitled " Penicillin."

In itself penicillin would have been entitled to great popular appeal—greater even than the sulphonamides. This has been doubly enhanced by the circumstances in which it is being developed. A few selected centres have been singled out for its trial and even these are on terms of partial secrecy, endowing it with the glamour of a secret weapon. Their choice lay, presumably, on many factors and Guy's is not amongst the few. The announcement of Colonel Schullinger's paper came, then, as a welcome stimulation ; the theatre was full and we were not disappointed.

However, such enthusiasm could not be entirely occasioned by the subject-matter itself. This was a talk by a visitor, which in itself excites especial interest, but also it provided an opportunity to get at first hand an impression of American scientific methods. Are their advances due largely to their unrivalled facilities for research ? Is their outlook essentially different from our own ? In fact, no mean responsibility lay on Colonel Schullinger's shoulders that evening. Any dearth of knowledge about penicillin was truly righted, to the betterment of our outside conversation and, soon, we hope, to our more able practical application of the drug. Our conscious inability to retain detailed statistical tables was confirmed, though not necessarily to our chagrin. Yet such a solitary meeting could not be made the basis of any extensive ideas and we left hoping that it would be the first of many such gatherings, that out of these would arise a more completely co-operative spirit between the two nations in medical, as in political, fields.

WE regret to announce the recent deaths, both on January 27th, 1944, of two members of the Governing Body of the Hospital. Robert M. Holland-Martin, C.B., had been a Governor since 1917 and was Chairman of the Estates Committee, in addition to performing useful work on the Finance Committee. Robert C. Nesbitt joined the Governors in 1934 and also served on the Estates Committee. Besides serving on the staff and school committee he was the Governors' representative to the Medical and Dental School. Their matured wisdom and knowledge of affairs would have been of great value in the re-establishment of the Hospital they both served so well.

Safety Factors in Anæsthesia and Analgesia

A Clinical Lecture delivered at Guy's Hospital on December 7th, 1943,
by A. D. Marston, M.R.C.S., D.A.

GENTLEMEN,—In answer to the question: "Which are the essential features of modern anæsthesia?" I suggest the following:—

1. Abolition of pain;
2. Immediate safety;
3. Achieving the stage of anæsthesia, the muscular relaxation and the type of respiration required by the surgeon; and
3. Freedom from any after-effects which might retard recovery.

The factor I wish to discuss to-day is *immediate safety*. This is all-important, and I venture to suggest that modern anæsthesia is associated with an increasing number of risks. From such scanty statistics as exist, one may conclude that both in the British Commonwealth of Nations and in the United States of America there are more fatalities and accidents than there were a quarter of a century ago. But it must be remembered that many more operations are being performed in these days, and on the strength of improvements in the technique of modern anæsthesia and in the treatment of shock, operation is to-day performed on many a subject who, not many years ago, would have been deemed too poor an operative risk.

This would account for the major portion of the increase, but special features of some methods in present-day use are also responsible. Such are:—

1. The use of a Boyle or other "gas machine";
2. Spinal analgesia; and
3. Intravenous anæsthesia.

METHOD 1.

It is the anæsthetist's duty to carry out a routine inspection of the apparatus before putting it into use. Neglect of this simple precaution may lead to explosion risks, or death from wrong coupling of cylinders to the flow-meter. Both of these unfortunate possibilities may be regarded as "accidents," but, in point of fact, we know that they are due to lack of care.

With regard to explosions, I would remind you that static charges of electricity are liable to develop on trolleys with rubber wheels, and more especially if the atmosphere be so heated and conditioned that the relative humidity is lowered. Therefore one must be sure that the trolley is adequately earthed by means of a chain. A static charge may also be developed by to-and-fro breathing in any dry rubber tubes unless the new conductive rubber is used. Hence one should wash out the tubes with warm water, if the apparatus has not been employed recently. At the end of any administration also, the bottles on the machine should be emptied, for if ether is left in its container there is a risk of "creeping" or "silent" flash.

The risk of static electricity leading to explosion is a very real one. Cases are constantly reported, and I maintain that prevention is possible if adequate care in inspection is constantly exercised by the anæsthetist. The recent increase in these accidents has led to resumed sittings by the Explosions Board, sponsored by the Institution of Electrical Engineers. We are given to understand that no new explosive factors have been discovered, but emphasis is laid upon the urgent necessity for an increased education of anæsthetists and theatre staffs in these matters.

In concluding my remarks on this subject I should like to remind you that when the diathermy or actual cautery is used it is not enough to turn off the ether bottle. This is an inadequate precaution, as evidenced by an explosion recently reported. Even when put out of circuit, the ether vapour is liable to leak through; thus it is *always* necessary to *remove* the ether container from the apparatus.

Wrong Coupling of Gases to Flow-Meter.—Although this accident might be considered improbable, this is by no means the case. As you know, the four gases in

common use are oxygen, nitrous oxide, carbon dioxide and cyclopropane, oxygen being essential at all times in sufficient supply to satisfy the demands of basal metabolism. The usual " accident " is to administer nitrous oxide with carbon dioxide in mistake for oxygen, and if the anæsthetist happens to be gazing at his flow-meter and not keeping a watch on the patient, there is no possible chance of the patient's recovery. The results of this " accident " are commonly observed during induction, but, in a recent case, the disaster occurred during maintenance, the oxygen cylinder becoming exhausted and a nitrous oxide cylinder being substituted in error.

Repeated attempts have been and are being made to construct " foolproof " couplings and to attain an international uniformity of colour code for cylinders and flow-meters ; but, in my opinion, the human factor must always be present, and a real exercise of care could prevent all accidents.

In recent months a " whistle " device has been perfected so that the anæsthetist may be audibly informed when his oxygen cylinder is empty. But all mechanical devices are prone to decay and to produce confusion, and it would indeed be sad for anoxia to prevail just because a whistle did not " blow " !

Surely our duty is two-fold. First, to be certain beyond all reasonable doubt that the correct cylinder is coupled to the correct tube in the flow-meter ; and, secondly, to keep an unremitting vigil on the patient's colour and respiratory behaviour. It is no excuse to blame others for incorrect coupling ; it is your moral duty to take this responsibility, and the lawyers will point this out to you in no uncertain fashion if you have a misfortune and seek legal aid.

Cyanosis with possible Anoxia.—Unless a blood count and hæmoglobin estimation have been performed prior to administration of nitrous oxide and oxygen, the mere observance of colour will not suffice as an indication of adequate oxygenation. In anæmic states a saturation of all available hæmoglobin may not satisfy the needs of basal metabolism, and the cutting down of oxygen in such conditions is the true cause of many so-called " mysterious " cases of sudden collapse.

In the case of children under ten years of age, I submit that no degree of cyanosis should be allowed to exist at any time, because although the so-called " status lymphaticus " has been officially denied any pathological entity, nevertheless, many clinicians prefer to keep children a good pink colour and, if this rule is adhered to, I am confident that few exponents of this view will regret it.

We must beware of bigotry in using gaseous mixtures and avoid the false premise of considering the addition of a volatile adjuvant a reflection on our professional prowess. The adjuvant commonly available to the occasional anæsthetist using a Boyle's machine is ether, and we know its use may be associated with after-results which do not conform to an ideal recovery from anæsthesia. But if we view immediate safety as a primary objective—and I for one subscribe to this—then instead of diminishing oxygen as a means of increasing depth of anæsthesia, we should rather add an adjuvant with an ample supply of oxygen and thus avoid the peril of anoxia.

METHOD 2.—*Spinal Analgesia (Subarachnoid Block).*

The many advantages of this form of analgesia have undoubtedly led to its more extensive use in recent years, and used with discrimination and scrupulous care one may confidently expect a continuance of its employment. Of its risks in inexperienced hands and unsuitable cases there can be no doubt, and these may be divided into *immediate* and *remote*. The latter are the more numerous, but it is the question of immediate safety which we wish to discuss to-day. Two common causes of accidents are the following :—

1. Whenever any spinal analgesic drug is used, there is always—and from a variety of causes—a fall in blood pressure and, as a general rule, we may say that the higher the spinal block the greater is this fall. Recognising this state of affairs, it is always necessary to take a careful blood-pressure reading and to examine the cardiovascular system. If you find a systolic pressure of less than 100, you may give a full dose of ephedrine ; if this does nor elevate the blood-pressure to at least 100 the case should be regarded as unsuitable for spinal analgesia.

2. If as an occasional anæsthetist you have no great experience in this type of work, you must be careful about the dosage and physical character of the drug you intend to use. Do not accept an unlabelled ampoule from a theatre sister, but insist upon seeing the box from which it has been taken.

Be sure that you know whether the drug you are using is heavier or lighter than the cerebrospinal fluid. If you do not know you must not take a chance. It may appear futile or elementary to mention such simple things, but it is necessary and so I do so.

METHOD 3.—*Intravenous Anæsthesia.*

Of all the derivatives of barbituric acid, pentothal sodium (Abbott) is the most widely used. In the hands of specialists in anæsthetics this valuable and efficient drug has proved most useful, and can be employed as a means of securing basal narcosis as a complete anæsthetic for short or continuous administration. But if used by the occasional anæsthetist without observing certain rules of caution, this mode of anæsthesia may be attended with considerable risks to immediate safety. These risks may be placed into three groups :—

(*a*) *Overdose.*—The potency and quick action of pentothal is rendered more controllable if the dilute solution of 5 per cent. is used as a routine for induction ; furthermore, if leakage into local tissues occur with this weaker solution, it is associated with minimal discomfort and damage. One to two cc. of coramine may with advantage be added to the solution in cases of debility, shock, anæmia and asthenia.

Induction should proceed slowly and with safety pauses at regular intervals. I have no good opinion of the " counting " technique. All too often the drug is injected rapidly and continuously until unconsciousness results. In a number of such cases it is recorded that respiration has thereupon ceased and, to the dismay of the anæsthetist resuscitation has sometimes proved unavailing. A slower method holds few disadvantages. Our practice is to give 3 cc. of the 5 per cent. solution in about a minute wait a few seconds, continue at 1 cc. per 15 seconds until consciousness is lost, then wait a full minute before any further injection is made. A partial amnesia results after the administration, and few patients remember whether their induction was slow or speedy. I suggest, therefore, that there is a genuine case for slow and intermittent induction with immediate safety.

(*b*) *Anoxia.*—Pentothal depresses the respiratory centre, and it is necessary for a good airway to be maintained ; but if the depression continues, the atmosphere will not supply sufficient oxygen and some degree of anoxia will result. This is a serious complication and needs immediate treatment. Oxygen should always be available and should be administered in all cases where the respiration is unusually depressed. Do not wait for anoxia to develop, but give the oxygen in advance of its need.

(*c*) *Intra-arterial Injection.*—This is a carasthrophe almost without parallel in the whole range of anæsthetic technique, and it can and should be avoided in the following ways :—

(i) One must realise that an aberrant artery is a definite anatomical possibility in the ante-cubital fossa.

(ii) Examination of the proposed vein should always be made before any pressure is put upon the upper arm. If someone has already compressed the upper arm, then it is your duty to feel the radial pulse ; if this cannot be felt, then the pressure must be relaxed until it can be felt. Only in this way can you ensure that the puncture is being made into a non-pulsating vessel.

(iii) Always watch the colour of the blood aspirated into the syringe ; the bright colour of arterial blood is characteristic and will surely be observed by the alert anæsthetist.

(iv) If through one cause or another you have proceeded to the actual intra-arterial injection, then please pay attention to the patient's complaint that his fingers and hand are suffering from sharp pain which may even amount to anguish. To cease at this point will, at any rate, secure a minimum of those after-results which, as you know, may be so disastrous.

In conclusion, may I observe that progress in anæsthesia, as in any other art and science, should be encouraged, and we must not succumb to the temptation to hark back to old and well-tried methods of anæsthesia. It has been said that " to be warned is to be fore-armed," and one hopes that in the welter of post-war reconstruction a tiny place will be reserved for the possibility of post-graduate instruction in modern anæsthesia.

Another Letter from "Sinbad"

MY DEAR BILL,—You should be getting ready for going to sea by now with the refit and working up over. I only hope this will reach you in time. As you can see from the address we are in a position to test what I am going to devote this letter to in earnest. During the working up period with the various exercises and practises, you will have some idea of what life in a small ship is like in winter. You are paid hard-lying money and, if you are in the North Atlantic, you will undoubtedly earn it. In winter life on board ranges from merely uncomfortable to the nearly unbearable. In heavy weather the mess decks stench of wet clothing, food, vomitus and closely packed unwashed men, for the sailors who normally devote much of their time to washing are forced to give up in high-seas. Occasionally you will get little or no food and nearly every day you will get wet. Once you know that you are going out you must secure everything in your cabin ; I expect that during the days you have so far spent at sea you have had breakages. Everything must be secure and have lashings ready even if the weather to begin with is calm. If you fail to do this you will be aroused by falling books and crashing chairs and be forced to do the job in the middle of the night. Drawers must be locked and cupboards doors also. Once you are sure everything is safe screw down the scuttles tight; there is a special key for this, which I have had to borrow from Number One. Fresh air is excellent, but, combined with salt water, there is no quicker way of wrecking a cabin. Don't have too much water in your steriliser or it will swill all over the deck. On leaving harbour you don the new officially blessed battle-dress, your life-jacket and rope harness. This may seem a little bit pessimistic, but you may have a collision or hit a mine in the most unexpected places and you can drown quite as satisfactorily in the approaches to a great port as on the high seas. Once out of harbour most people start sleeping in their clothes and the further out the more clothes. I have only once slept in my boots, as this is only necessary when an attack is imminent. In the U-boat area it is wise to have everything you may need in an emergency to hand. A bag containing essential instruments and drugs and dressings should be ready packed ; such clothes as you have taken off hang up with outer garments underneath (the reverse of the ordinary process), red lamp clipped on to the lapel of your oilskin—everything ready for a quick move. Once in your bunk leave one light on so that if something should happen you won't waste time fumbling for the switch and, if you wake up with a crash and find the lights out, you know it is time to move—a very experienced seaman who has been sunk three times tells me that if the lights go out it is time to find out what has happened. To be ready for such an emergency have a torch at hand by the head of your bunk so that you can get hold of it without delay. You might suppose from the foregoing paragraphs that you will hardly have a moment's relaxation ; in practice you soon do it without thinking, but if anything should go wrong it is as well to be ready.

Outside your cabin the first thing is to hold on tight; this applies everywhere, and I will reiterate it monotonously throughout this letter. You always go down ladders backwards ; it is the only way that ensures a good foothold and handhold. In rough weather the waves will break over the upper deck, and as there is no way from forrard aft except along the deck you must study the best way of avoiding danger. I don't pretend to be a seaman, but this advice has been vouched for by several officers who have spent plenty of time in destroyers and has been tested on a number of occasions by me. If it looks very rough go up to the bridge and ask the officer of the watch whether it is a good time to go aft or not. He will then tell you when the ship is on a steady course or will advise you to stay up forrard. When you know it is safe choose the lee side ; this is the side towards which the ship is leaning over. The weather side, which is higher out of the water, seems safer and dryer to the inexperienced, but it is waves sweeping over this side which are one of the main dangers. Further investigation has convinced me that there is no "golden rule." In general the lee side is safer but wetter, but there are notable exceptions to this, so that you would be well advised to consult the officer of the watch on doubtful occasions. You will, of course, be wearing your life-jacket and harness, and it is wise to get a pair of leather gloves, which allow you a good grip. In rough weather life-lines are rigged ; these consist of ropes running the length of the deck, and there are usually two of these on each side in the more exposed places. Outside these are the guard rails, but they are not intended for your support and are only a last hope. Hold on as tight as you can and watch the weather side to see if a wave is sweeping towards you. If you see this get off the deck by climbing on to a gun, the searchlight platform or anything you can find. Should,

however, none of these be available, then hold tight with your hands and let your legs be swept away; in this way you will reduce the chances of being swept overboard. You will find that even eighteen inches of water coming across the deck hits you with unexpected force.

Once you reach the wardroom don't imagine you are safe unless you are wedged deep in a solid armchair which has been well lashed in place. Early this year I split my jaw open and lost two teeth when a boisterous wave flipped up the ship's stern and knocked me out of a corner seat of the wardroom to land about fifteen feet away. The patients who are being nursed in bunks should be lashed in; otherwise they may fall out and do themselves serious injury, especially if they have been narcotised.

Your first-aid organisation must be simple and flexible, the aim being to have as many people as possible knowing about the principles of treating a hæmorrhage, shock, etc., rather than attempting to train a very few expert ones, for, in the event, you will find that your experts may well have been detailed for some job to keep the ship afloat. Rehearsals have a certain limited value. I devote most of my time to instilling a few principles and teaching the various carries, for it is the transport of wounded in a ship that presents such enormous difficulties; but, in any case, as we discovered in the "blitz," you learn more from half-a-dozen casualties than a hundred rehearsals. Frequent mental rehearsals of your own are undoubtedly helpful combined with the question, "What do I do if . . . ." and these usually reveal weaknesses in one's organisation, technical ability and equipment. The whole subject of carrying the sick at sea is full of difficulties and provides one with small but fascinating problems. Have your Thomas's splints prepared with pins and bandages and the Milbank clip is a good way of fixing the foot and securing traction without removing the shoe; in default of this a sharp skewer can be used, but this seems to me to be liable to be pushed through the sole of the foot. When in convoy it is always possible that another ship will want your assistance. The captain decides whether the health of his own ship's company and the state of the weather justifies you being sent. The first thing is to find out what is wrong, since you will have to depend largely upon your own equipment. Liberty ships seem to have plenty of medical stores, but our own incline towards quantities of purges. Once you have got all possible information you select your own gear, pack it as firmly as possible and go to the boat. When signalling to other ships for information about the sick use the simplest language; don't ask for symptoms or signs, but "Where is the pain. Does it hurt all the time?" etc. There may be no one on board who speaks English and your signal will have to be tramslated from a dictionary. It is no responsibility of yours how the boat-work goes, so you are able to watch the crew at work. Observe the method of lowering into the water and note how much larger the waves appear from a whaler than from a ship. When you come alongside the ship you are presented with the problem of getting out of the boat; they will have lowered a tiny dangling ladder which, as the ship rolls, leaps high into the air at one moment and splashes in the water the next. The leading seaman in charge of the boat tells you the best place in the boat for you and you clamber forward from the stern sheets. Let the ladder swing down to you once or twice so that you can get some idea of the speed of the roll and then, when it comes opposite the boat, nip on to it and climb the first few rungs as quickly as possible. If you don't you are liable to be wetted by the sea or even crushed by the boat when the next roll brings her up again; above all, hold tight, for provided you do this, not much harm can come to you. The advent of a doctor on board is a signal for all and sundry to produce their ailments. I went over to see an early pneumonia and ended up with the original patient, two cases of gonorrhea, a Chinese gentleman whose piles pained him when he ate curry (I advised a visit to a surgeon on reaching port and no curry until then, which gratified him); a Colombian, with lower abdominal agony and a lump in the groin, this was a bit worrying and I had to delve in my mind for all I had forgotten about hernia; however, it wasn't a hernia, and investigation showed that he was to be arraigned for knifing a fellow sailor and that the day before he had raided the galley. I suppose he had had that vaginal hydrocele for years. You may be left on board for some hours or even spend the night out of your ship. You will find the merchantmen very hospitable, but before turning in it is as well to ascertain the way out from your cabin to the boat-deck just in case a hurried exit should be necessary. Then after-care of patients treated out of the ship is not easy; it is best to leave detailed instructions for three to four days because it is probable that you will only be able to keep in touch by signal. Make arrangements for them to communicate once daily with you, but even signalling is provisional upon the weather, high seas and squalls make it impossible to get even essential operational signals. Do not be surprised if your captain or the group leader

decides he cannot send you over for what may sound a serious case; he will do his best, but the escort's primary job is to screen the convoy and, in a danger area, the risk of two ships falling behind may be unjustifiable.

My next letter will deal with clinical matters and treatments and various miscellaneous points, but don't think I'm setting myself up as an authority on these things. If you have some better ideas than mine please tell me because I want to know.

Your old Friend,

The Matelots' Medico,

"SINBAD."

H.M.S. *Verucca*,
At Sea: Long. 30 W., Lat. 50 N. approx.,
December, 1943.

No. 1 General Hospital, Nairobi, Kenya

By K. M. OGDEN, T.A.N.S. (Guy's 1934–1938).

THIS hospital is an emergency war-time one and is built on a large tract of land that had been used as a cattle show ground. Each ward is a separate hut standing at the side of a road which runs round the hospital, and most of the huts have thatched roofs and mud floors. The gardens and grass outside the wards and the beautiful tropical trees shading the roads and surrounding the parade ground make the hospital a very picturesque place.

The wards themselves are airy and fairly light; the thatched roof keeps them cool in the heat of the day and dry and warm at night. It is very difficult to make the wards look clean and tidy, as the mattresses are of very thin straw, and it is hard to make the orderlies do good "corners" and, however much the floor is swept, it still looks dirty. Also the mosquito-nets all tend to hang at various angles, rather spoiling any attempt to obtain uniformity. Large tables with cupboards underneath them are built at intervals down the wards, and in these are kept all our equipment which is plentiful considering that it is a war-time hospital. We only take African patients, save for one small Asian ward, and our nursing staff, excepting the sisters, are all African boys and men.

When I first arrived here and was shown my ward with its rows of beds, each containing a black boy and all the orderlies in khaki shorts and shirts and little round hats, I thought that I should never become accustomed to them and certainly never tell one from another, but in a month I found it all quite simple, and now, after eight months, I begin to wonder what it would be like to look after Europeans again. I had some terrible shocks at first and had almost to reconstruct all my theories of nursing. Patients almost dying one day will get up and go and sit on the damp grass the next and be none the worse for it; on wet days they go outside with their bare feet and get covered in mud and then pop straight back into bed, mud and all. Their food is all eaten with their fingers and they, of course, have to us a very strange diet, subsisting on rice and maize flour, with beans and stew occasionally. Having patients on fluid or light diet is a problem, for they do not like butter, milk and eggs at all. And it is very difficult persuading them to take this sort of diet. My ward is medical, and I should think that always 75 per cent. of the cases are suffering from lobar pneumonia, from which disease they usually recover rapidly, being ready for discharge in about ten days' time. Dysenteries of all sorts, bilharzia and relapsing fever make up the remaining 25 per cent. Practically every man has worms of every sort and a +++ Kahn!

I have a training ward—that is, I have eighteen orderlies who just know the rudiments of nursing, to train into Grade II orderlies who are supposed to know quite a lot. I have them for two months, the third month of their training being spent in a surgical ward. To help me I have two corporals who have both fully trained as nurses in a Uganda hospital and who are both excellent. There are five wards who do medical training, and we three sisters who run the wards each take it in turns to do the lecturing for a month at a time. The first month the boys have simple things taught them such as how to take temperatures, collect specimens, disinfect, and do such practical things as fomentations, poultices and give medicines. In their second month they are taught about the common diseases they nurse in the wards—lobar pneumonia, the dysenteries, typhoid fever, bilharzia, worms, cerebro-spinal meningitis,

malaria, and mumps and measles—and are taught to lay trays for lumbar punctures, aspiration of chest and other simple procedures. Their third month is spent in learning to do dressings and nurse surgical cases, and at the end of this time they take their examination. If successful, they are posted to field ambulances and casualty clearing stations.

The syllabus is a long one and, considering that the lectures and demonstrations are all given in English, and many of them have an imperfect knowledge of it, they really do extremely well in such a short time. Some of them are really intelligent and interested, but, of course, we get our share of the really stupid ones.

The work is interesting although it can be exasperating, for very few Africans ever remember to-morrow what was told them the day before, and to get the cleaning done and the ward straight and the patients cared for needs constant vigilance and supervision.

I have had some very amusing answers to questions set them. On the subject of laying out the dead especially have I had some good ones, such as : " I tie up his jaws and cross his eyes and then plug his obvious openings ; then I take the remains to the Quartermaster." But these are only language difficulties, and I have no right to laugh at them, for my struggles in Swahili are always received with encouragement, and I am told how much I am improving, which is a great exaggeration, for I find the language difficult to master. The African is very courteous and gentle-mannered and addresses us as " Momma," which always strikes me as a rather funny title, and I often want to laugh as I go down the ward saying " *Jambo,*" which means " Good morning," and get the reply " *Mzuir momma.*" And their names, too, are priceless, the orderlies always being called by their Christian names—Meshach, Gideon, Lothario, Deogratias, Elias, Kingeorgy, Buses, Brave, Kolynos, Grevazio, Angolivisye, and, of course, all the Biblical names are popular, and many of them have European surnames as their Christian names—Wilsons, Harrisons and Sylvesters are very common. But I think the funniest one I have met is Davisbilly !

I quote at length a rather sweet letter sent to a colleague from one of her trainees, as I think it would amuse you—the rather dramatic way in which the beginning is made.

" Just here."

" Madam,—Ah it is indeed unpleasant to go a walk without any penny in my pocket. Ah I am pocketless indeed so due course I have the honour to notify you so that as regard to your kind consideration you can to be able to lend me 2*s.* or 3*s.* if possible. Kindly I shall give back on Monday or the day after to-morrow if I receive my payment. Please apologise me for the trouble given to you on reading and spending your valuable time account of my letter. Awaiting of favourable reply then believe me to be your dutiful boy, pupil and son " LEONARD."

I had a long letter from one of my trainees who had gone to another unit and he ended with this : " God may clear for you every harmful thing to the life so that all obstructions and abnormalities to the general condition may be far from you." A blessing that is very appropriate in my way of thinking to every one of you undergoing hardships and strains at home.

Impressions of Nuffield House

BY " THAT MAN IN NUMBER NINE."

I HAVE been Exhibit A at Guy's now for two weeks. Rubies, or carbuncles, or something, on my back.

" Splendid ! " said the Doctors, when they examined me.

" Fine ! " said the Nurses, when they bandaged me. " They are getting bigger and bigger."

" Short wave treatment," said my Specialist. " I'll make arrangements for you."

So they sat me down on a chair in front of something that looked like a boot-cleaning machine and lowered two steel arms with loud-speaker attachments against my body.

" Tell me if it burns you," said the lady operator, as she pressed Button A.

I assured her fervently that I would.

Then the House Surgeon of the Electrical Department, who looked remarkably like Anthony Eden but without the Eden smile, came to view me under process.

" Are you an Out-patient ? " he asked my back.

I nodded my head in short waves and replied " Yes."

"Then you must come inside," he commanded. "You can't walk about with those decorations."

So they conveyed me to Nuffield House. It seemed a very nice hotel, I thought, at first, but I soon found the rules were different. For instance, just as I was about to take a bath on the first afternoon a Nurse brought in my tea.

"Take that back for a little while," I said, in a lordly manner; "I am just going to have a bath."

The Nurse looked rather surprised, but she took the tray away and I proceeded to the bathroom. I never reached it though. Somebody came quickly down the corridor and intercepted me. She was a high-up Nurse I could see, because she had a white bow beneath her chin, and I believe that denotes something.

"You can't take a bath now," she said. "You are under treatment, you know."

My lordly manner fell from me. I apologised and went meekly back to my room. My tea was already there waiting for me, so I realised they meant what they said in Nuffield House. I had hardly finished my tea before the same high-up Nurse, smiling this time, came and told me that I could have my bath now.

"Are you the Sister?" I asked in a subdued voice, just in case she was.

"No; I am the Nurse," she replied.

I brightened up. After all, she wasn't the Sister. I gathered some of my lordly manner back.

"I won't take my bath now," I drawled. "Later on, perhaps."

She went out without saying anything. Honours even.

Then the day afterwards I met the Sister. She's lovely, but she is very insistent on one idea, or, rather, two ideas—bed and rest. Now, as I have to go out twice a day to my electrical dry cleaning with the boot-machine, it is obvious that I must get out of bed and walk. But as sure as ever I walk along the corridor Sister meets me and says, "You must really get to bed, you know; it's rest you want—rest and rest."

When Sister wasn't looking the other day I explored upstairs. There is a full-size billiards table there covered with a cloth.

I grew bold. I went down and saw Sister at her desk. She drew first blood though.

"Why aren't you in bed?" she asked.

"I am just going, Sister," I said. "Only I was just wondering if, when—when—I get a bit stronger, I could go up and knock the balls about?"

"That table," said Sister, "belongs to a doctor."

"Oh!" I answered. "That's all right; I daresay it is still playable. He may not have torn the cloth very much."

She laid down the pen she was using to add up temperatures and pulses and things, and said sweetly: "That table is private and confidential. It is not for patients; and, besides, it is bed you want, bed and——"

"All right, Sister," I interrupted; "I know the *rest*."

So I went to bed and listened to the old rooster who lives in a world four feet square, in a back yard beneath my window. Listened to him crowing away with a fruity voice like a City Alderman, and I thought to myself: "If that old cock can be content why shouldn't I?"

But as I am leaving Nuffield House to-morrow morn I must be brief with my story.

Had I the time I would tell of the wonderful care Sister has bestowed on me; of the master touch of her gentle fingers; and of the good her bed-and-rest medicine has done me.

I would tell of the morning tonic I receive when our charming Night Sister greets me with a happy "Good morning."

And, even most of all, I could tell of the wonderful Nurses who tend you, mend you, nurse you, and still keep on smiling as if they really liked you, when, if they let their natural instincts flow, I am sure they would go round each room with a lump of wood and crack you a good one, as you lie in bed with your finger on the bell-push.

Yes, and I would tell you of the nice House Surgeon here—the one with a cathedral voice and a name that smacks of Cornwall, who comes to cheer us up.

And last, but not least, I would, had I the time, tell of my own Special Doctor, who always comes in smiling, but here I give a warning. Never tell him you feel better, for each time I have said, "Yes, I feel much better to-day" he has smiled and said: "I had better give you another injection."

And, just as a footnote, I would add that I guess Nuffield House has done my wife good, too. For six long weeks she nursed me devotedly at my home, until the doctors, probably for her sake as well as mine, rounded me up and corralled me in what, I am sure, although I have no experience, is the finest nursing home in London.

R. B. H.

Correspondence

PULMONARY TUBERCULOSIS.

To the Editor of the GAZETTE.

SIR,—It is with some concern that I have observed a number of my colleagues developing pulmonary tuberculosis in the last eighteen months. This number seems to me to have a higher incidence than is expected under present circumstances and professional risks.

On this subject I have written to other medical schools to find whether such a parallel increase is also evident among their students. Their replies on the whole have not suggested that there has been any unusual increase similar to ours. This recent phase may be because the soil at Guy's has been particularly favourable to the tubercle bacilli; but perhaps future recurrences can be guarded against and minimised if some serious thought is given to it now.

Yours, etc.,

Guy's Hospital Medical School. I. T. THE.

Sport

Rugby

GUY'S *v.* ROYAL NAVY, PORTSMOUTH.

(*Played at H.O.P. on Saturday, February 5th.*)

Result: Royal Navy, 21 points; Guy's, 6 points.

The less said about this game the better. To justify our poor display it may be said that we were very depleted, especially in the back division, which had been so shuffled as to be almost unrecognisable.

We started badly and were soon 8 points down, but the deficit failed to inspire the side. Instead, Lieut.-Comdr. Hammond, a peace-time English trials player, was allowed to dribble the ball half the length of the pitch almost unmolested, to score a try near the posts. This was converted, and the Navy scored once more before the interval so that we changed over 18 points down.

Guy's improved in the second half and the forwards played with more vigour, but the backs never looked dangerous. However, it was Boyd who initiated our only try by cleverly intercepting a pass and making a good run before drawing the full-back and passing the ball, for Carton-Kelly to score. Gullick failed to convert, but a little later kicked a penalty goal to conclude our scoring.

Jones did very well in his unaccustomed position at full-back, fielding cleanly and kicking some long touches.

Team.—D. G. Jones; D. R. Edwards, I. G. Davies, D. C. Boyd, A. C. Macrae-Gibson; E. W. Graham, J. Pugh; R. G. L. Brittain, A. B. Lee, R. A. Dean, C. Ziervogel, D. Gullick, P. S. Carton-Kelly, C. Vidot, P. D. Harvey.

Hospital Information, etc.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
January, 1944.

Surgery.—*P. E. Mars.

Pathology, Bacteriology and Forensic Medicine.—A. W. Banks, *R. K. Haslam, A. M. Earle.

Medicine.—E. D. C. Jones, W. H. Lillywhite.

Midwifery.—*D. E. M. Brown, *P. E. Mars, *D. A. Tait, E. A. Wright, E. G. Wright.

* Have completed the examination.

ROYAL COLLEGE OF PHYSICIANS.
M.R.C.P.
January, 1944.
A. W. Taylor, M.B.

Appointments

Miss D. M. Ellemint, S.R.N., S.C.M., Sister Tutor, Royal Berkshire Hospital, Reading.

Change of Address

W. G. C. Dickson, L.D.S., R.C.S., 4, Ormerod Road, Bristol 9. Tel.: Stoke-Bishop 82625.

H. G. Floyd, c/o D.M.S., Entebbe, Uganda.

John A. T. Griffiths, Leaton, Gronant Road, Prestatyn, Flintshire.

H. F. Lunn, Major, R.A.M.C., H.Q., 4th Div., M.E.F.

W. S. McConnell, Major, R.A.M.C., 133 I.B.G.H. (B.T.), Bareilly, W.P., India.

Births

TAYLOR.—On January 19th, 1944, at Tunbridge Wells, to Margaret, wife of A. W. Taylor, M.B.—a son (Martin Francis).

Deaths

CLARKE.—On January 11th, 1944, at Reading, Henry Milford Clarke, M.B., B.Ch., of Wakefield Lodge, Reading.

HANKEY.—In January, 1944, of typhus, while serving with the British Red Cross Unit to China, Donald Hankey, M.R.C.S., L.R.C.P., of Semley, Wilts.

MONTAGUE.—On February 14th, 1944, William John Montague, M.B., B.Ch., of Oakmand Lodge, Copthorne, Sussex (late of Guernsey).

PURNELL.—On January 22nd, 1944, at Streatham, Purnell Purnell, M.R.C.S., L.R.C.P., of Leigham Court Road, S.W.16.

ROSEVEARE.—On February 14, 1944, in a sanatorium, Edwin Russell Roseveare, Surg.-Lieut., R.N.V.R.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE publication of the Government's White Paper marks the opening of the second round of the tussle on a National Health Service. The first round, in which the Beveridge Report appeared, ended in a stalemate with the Government retiring to prepare its second blow which now appears as the White Paper.

With its publication we shall have some positive grounds upon which to argue and to make constructive criticism, for these proposals are merely the tentative outlines of a plan designed to ensure "that in the future every man, woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health" and that no one "must have reason to believe that he can obtain more skilled treatment by obtaining it privately than by seeking it within the new service." These general principles are the very cornerstones of the scheme. No physician, imbued with the humanist sympathies of his profession, can dare to reject them however much he may be in doubt concerning the stones which will rise above them to complete the structure.

In accord with British democratic spirit, the scheme has all the features of a compromise in what is, admittedly, a very delicate situation. The general practitioner still remains to fulfil his very important *rôle* of "family adviser." He is at liberty to ignore completely the Government scheme as before, but there arises a new creation —the G.P. working in close contact with the Health Centre. This latter idea, even if the scheme falls about it in ruins, should surely remain, for it is the legitimate offspring of the idea of positive health which forms the basis of the plan.

The "family doctor" is termed "the first line of defence," but now he no longer fights alone without the faintest notion as to the state of the battle on his flanks; he is able now to collaborate with his fellow physicians and with the Health Centres and Clinics. Moreover, the majority of the G.Ps. will be centrally directed and advised by a new body, the Central Medical Board, which overrides local administrative bodies. This board is composed of medical personnel working in close co-operation with the Minister of Health and makes itself responsible for the economical distribution and use of medical man-power. These ideas for the G.P. service can only mean an increase in the efficiency with which patients are treated without in any way losing that doctor-patient relationship which the opponents of the scheme are so afraid will be shattered.

At any rate, group or co-operative practice, already in action in many parts of the country, has come to stay and to grow.

The status of the voluntary hospitals remains virtually unaltered provided that they abide by their contracts, financial and otherwise, with their local authorities. The discerning will note that this means the thin end of the wedge leading to total absorption of the voluntary hospitals into the municipal service. However, the teaching hospital provides a separate problem of its own, since it will have to remain primarily a general hospital in possession of that spirit of intellectual freedom which is the prerogative of the centres of higher learning. These centres must not be obstructed by bureaucratic ham-stringing.

In addition, there will obviously have to be many more teaching hospitals or an increase in the membership of the existing ones in order to cope with the expansion of the profession, particularly the consultant service which the scheme demands if it is to function properly. Moreover, we shall have to alter our prejudices about women students for they will be bound to play an important part in the development of the scheme.

Finally, we should be fools if we underestimated the importance and relevance of the White Paper and were to expect this medical Utopia to appear overnight. It will be some few decades before the scheme, if accepted as it stands, will be working smoothly, for it is immensely ambitious representing the final changes in a continuous century of progress towards a positive health programme, whereby every man, woman and child can live in as reasonable a state of health as scientific progress and economic conditions will allow.

FORMER Guy's students will probably have read with regret of the recent deaths on February 17th and 18th respectively of Dr. John Eyre aged seventy-four, consulting bacteriologist ; and of Dr. John Fawcett, aged seventy-eight, consulting physician. An Obituary notice and appreciation of the life and work of Dr. Fawcett appear in this issue. We hope to be able to publish an obituary notice of Dr. Eyre in our next issue.

THE following Guy's men appear in the latest R.A.F. appointments list:—Air-Commodore A. F. Rook, O.B.E., to the acting rank of Air-Vice-Marshal and consultant in Medicine; Air-Commodore C. P. Symonds, C.B. to the acting rank of Air-Vice Marshal and consultant in Neuro-psychiatry. We are very pleased to be able to congratulate Air-Vice-Marshals Rook and Symonds on their promotions and to record the honour indirectly bestowed upon the Hospital.

THE Anatomy Department would be very grateful if any students in possession of a recent edition of Gray's "Anatomy" would be willing to sell or to lend this text-book for the use of those students who are finding it impossible to purchase a copy. If a student is willing to lend his Gray's "Anatomy," it is suggested that it be done on the condition that the recipient should deposit with the Medical School Office a sum equal to the value of the book, such sum to be refunded on the return of the book to the Medical School Office in good condition.

As this problem is most acute, it is hoped that those students who can will be willing to co-operate in this scheme. If copies are left in the Medical School Office they will be passed on to Dr. Whillis at Tunbridge Wells, for sale or loan as directed.

WE should like to take this opportunity of thanking subscribers for so promptly returning their *Gazettes* (having read them, we trust !). We hope in the near future to be allowed a further supply of paper but till then we must ask readers to put up with the shortage for a little longer and to share whenever possible. If you are quite unable to get hold of a copy, write to the Manager at the *Gazette* Office. This also applies to those who need back numbers for binding purpose. We may have one or two copies of the issue you want.

THE Index for Vol. LVII (1943) is now ready for distribution and may be obtained free of charge from the *Gazette* Office or the Wills Library.

Obituary

JOHN FAWCETT, M.D., F.R.C.P.,

Consulting Physician to Guy's Hospital.

JOHN FAWCETT is dead and his innumerable friends mourn the loss of a man who never made an enemy, and whose fine character was recognised by the many generations of Guy's men to whom he was affectionately known as "Honest John." Nobody who worked with him as a colleague or under him as a student could fail to learn from him many invaluable lessons both in medicine and in conduct. He loved Guy's, and from the day he entered the Hospital sixty years ago until the day in December, when, for the last time, he attended a meeting of the School Governors, he never missed an opportunity of serving the Hospital and School.

John Fawcett was born in 1866. He was educated at Dulwich. His interest in his old school never flagged, and he was greatly pleased when a few years ago he was elected a Governor of the College. In 1931 he helped to found a trust to assist the sons of Old Alleynians, and he remained its treasurer until his death. He worked hard whilst a student at Guy's and had little money to spare for recreation. He was a fine rugger forward and remained an enthusiastic supporter of the Guy's Rugby Football Club, of which he was President for several years. After serving as house-physician he became Demonstrator of Physiology. He was a Beaney Research Scholar in Materia Medica and did some good work on the drug treatment of gout with the help of a future President of the Royal Society, Gowland Hopkins, who was his fellow demonstrator under Ernest Starling, the greatest physiologist of his day, who was at the time head of the Department.

Though he was greatly attracted to medicine, and especially the traditional Guy's approach through morbid anatomy, he was also much interested in surgery, and for a time was undecided about the branch of the profession he would follow. This explains why he became both M.R.C.P. and F.R.C.S., an unusual combination for a physician. Eventually the influence of Sir Samuel Wilks and Sir James Goodhart led him to decide in favour of medicine. For a short time he was assistant physician to the Royal Free Hospital, resigning when he was elected to the staff of Guy's. Meanwhile he had passed the London M.D., and in 1902 became F.R.C.P. In 1923–4 he was Senior Censor of the College. For several years he was Dean of the Medical and Dental Schools at Guy's, and after his retirement from the active staff he continued to show his interest in the School as one of its Governors. His good work as Dean at Guy's, Censor of the College, and on the Senate of the University had so impressed the authorities of St. Thomas's, that they gave him a warm welcome when he was appointed representative of the University on the Council of their Medical School. He was very happy in being able in this capacity to add a new bond to the old established friendship between the two "Borough Schools."

Fawcett was deeply interested in the medical charities associated with Epsom College, of which he was Treasurer for several years. He took an active part in the work of the Invalid Children's Aid Association as Vice-Chairman of the Executive Committee and Chairman of the Bermondsey Branch.

At Guy's, Fawcett was Curator of the Museum during his time as Assistant Physician. He was an admirable demonstrator of morbid anatomy both in the museum and the post-mortem room, in the days when most of the work there was done by assistant physicians and not by professional pathologists.

During the war of 1914–18 he served as a major, R.A.M.C., on the staff of one of the London base hospitals. His work there occupied most of the little time he could spare from Guy's, where he did all that was possible to help to fill the gaps in teaching caused by the absence of three of the assistant physicians serving in the Army.

John Fawcett was not an inspiring teacher and his ward rounds were often dull. In spite of this his house-physicians, clinicals and clerks often learnt more from him than from the interesting and amusing rounds of some of his colleagues. He taught thoroughness and honesty, and they were taught to regard their patients as human beings and not simply cases. His examinations were so complete that it seemed impossible that he could miss anything. At a time when many superficial thinkers were inclined to believe that the days of the old-fashioned clinician and the old-fashioned clinical methods were past and that a short cut to diagnosis lay in the laboratory and X-ray room, the teaching of men like Fawcett was especially valuable. He did not undervalue the use of the new methods, but he placed them in their proper perspective.

Fawcett greatly enjoyed his shooting holidays in Scotland, and he also enjoyed fishing and golf. He contributed little to medical literature as he found writing an uninviting labour. He was conscientious in everything he undertook and never let anybody down. He was always punctual and went round his wards regularly four days a week. Only his colleagues were aware of the amount of time he gave to the business of the Hospital and School, but everybody appreciated his keen sense of duty and his unfailing kindness.

There are many great names in the records of Guy's. But in the two hundred years since its foundation no man has left behind him a finer record of devoted service to the Hospital.

A. F. H.

An Appreciation

JOHN FAWCETT

WHEN, as a small boy, I first knew John Fawcett, he lived in St. Thomas' Street. He was to me then someone who showed me London from the top of a horse-drawn 'bus; who took me for a ride in the then new Twopenny Tube, all the way from the Bank to Shepherd's Bush, or to see the model locomotives at the Science Museum, and who decided that I was about the age when one might be allowed to stay up to dinner; in short, treated me like a father.

This is not the place to speak of my personal debt of gratitude to him—a debt that accumulated from my childhood to his death, nor do I pretend to be able to pay anything approaching an adequate tribute to his memory. I can only try to outline a few facts which may serve to convey some idea of the kind of man he was.

In those early days he was spoken of as "Honest John" by everyone, a title which fitted him perfectly, as did also the perhaps rather more affectionate "Old John," by which he was known later in my days at Guy's. Single-mindedness and honesty were indeed the essence of his nature; it is impossible to think of him otherwise. He believed in the things that had been tried and found good, and most of all he believed in Guy's Hospital and its traditions.

In outlook John Fawcett was essentially conservative, and this was reflected in his teaching. He taught us what he knew by the light of his own sound judgment and experience, and his memory was prodigious. He believed in overlooking nothing, and if his clerks and house-physicians were expected to put a little more labour into their duties than might sometimes have appeared to be strictly necessary, many of them must be grateful for the very high standard that he set himself and expected of them, and for having learned from him the things that must never be left undone. He liked solid workers, and he was quick to recognise talent; at the same time he was sometimes rather unexpectedly patient with chronics. There was probably something in them that he liked anyway; it was never too late to mend, and he often spoke of some of these hospital "institutions" who had afterwards made a success of practice. He never forgot the men he taught, and nothing gave him more pleasure than seeing them again or hearing news of them and, best of all, doing something for them when he could.

Physically robust, John Fawcett in his young days was a good footballer and cricketer. He played in the Guy's Rugby XV from the beginning to the end of his days as a student. Rugby football remained one of his permanent interests; he thoroughly enjoyed a good match, and watched the hospital games as often as he could, knew many of the players, and for a good many years before he retired, he was president of the Guy's Rugby Football Club.

Of his services to Guy's and the profession generally in other fields I cannot speak from personal experience; one may be sure that they were all of a piece. He gave his all to his work, possibly more than was good for his personal welfare, for, not many years after his retirement from the staff, he developed the long and distressing illness from which he never fully recovered. The kind of retirement to which he had looked forward, and so fully earned, was denied him; he had in front of him only a long period of suffering to endure as patiently as he could. His outdoor recreations, shooting and golf chiefly, had to go by the board; but he kept on as much of his voluntary work as he could, remaining Vice-Chairman of the Invalid Children's Aid Association, a member of the Council of Epsom College, a Governor of Dulwich College, and a representative of the Board of Education on the General Nursing Council. He was also Vice-Chairman and Treasurer of the Old Alleynian Endowment Fund, a now flourishing fund which he started himself after his retirement. In later years he was much distressed at the knowledge that he was becoming less and less able to pull his full weight in all this work; it was work that he found congenial and for which he was exceptionally fitted by his talents an long experience.

And now at last we must say "good-bye" for ever to this simple, kindly, selfless man, who did more than his bit in this world, and most of it for the Hospital he loved so well.

G. B. D.

The Treatment of Simple Fractures

From a Clinical Lecture delivered at Guy's Hospital by T. T. Stamm, F.R.C.S.

GENTLEMEN,—Before the principles which should determine the treatment of fractures can be appreciated, it is essential that the physiological processes of repair which occur in the affected limb should be understood. These processes take place in three distinct situations—immediately around the fracture; between the broken bone ends; and in the rest of the limb. All fractures result in a considerable amount of hæmorrhage, so that at first blood, and later blood clot, will be present between and around the bone ends, and blood will be extravasated throughout all the surrounding soft parts. There will also be a traumatic inflammatory reaction, most marked in the tissues immediately surrounding the fracture, its degree and extent depending upon the nature and severity of the damage sustained. This reaction persists for a variable time during the period of repair and is related to the amount of irritation to which the tissues are subjected during this period. It will be best to consider separately the subsequent changes in the three areas mentioned:—

1. In the area immediately surrounding the fracture a mass of blood clot intervenes between the surface of the bones and the periosteum, which is lifted up from the surface of the bone over a variable distance. This blood clot very rapidly undergoes organisation into young bone, at first uncalcified, which constitutes the external callus. The process is accelerated by the inflammatory reaction, but the final calcification of this new bone is delayed so long as any inflammatory reaction is present.

Thus movements of the bone ends on one another or any other form of irritation will tend to increase the amount of external callus formed, but will delay its calcification.

This external callus represents Nature's method of providing a temporary splint to assist the final and permanent repair to take place between the bone ends themselves. Once this process has occurred most of this external callus is gradually reabsorbed. It follows that, in so far as the part of this picture is concerned, a small amount of movement between the bone ends is beneficial in the early stages of repair, since it promotes the formation of external callus. Once this callus has formed it is detrimental, since it will cause the inflammatory reaction to persist and delay calcification of the new bone.

2. Between the bone ends themselves the blood clot is rapidly organised into a fibro-cartilaginous mass composed of a fibrous matrix in which lie islands of hyaline cartilage and bands of fibrocartilage. At the same time there is some degree of aseptic necrosis of the ends of the bones owing to destruction of their blood supply.

New blood-vessels, together with osteoblasts, now commence to grow out from the living bone into this area, absorbing the fibrocartilage and dead bone and replacing it by new bone. The process is one of creeping substitution proceeding along a front from both bone ends, so that eventually the two fronts meet and union is complete.

The process of bony union between the bone ends does not, therefore, commence immediately, and the time that it takes to reach completion will depend upon the distance between the fractured surfaces.

Therefore, movements of the bone ends in the very early stages will not adversely affect ultimate union, provided that they are not sufficient to cause displacement of the fragments on one another with consequent loss of reduction. On the other hand, movement during the later stages of repair, when the two advancing fronts of new bone are endeavouring to meet and unite, will impede this process and is likely to lead to delayed union or non-union. Further, the time taken for union to be completed will depend upon the accuracy of reduction since the more closely the fractured surfaces fit together, the less the time taken to bridge the gap.

The replacement of the intervening fibrocartilage by bone will also be dependent on two other factors. In the first place the circulation through the limb must be adequate. If it is deficient owing to lack of muscle activity, the process is slowed down or may cease altogether. The second factor on which the formation of this new bone appears to be partly dependent, is the presence of the physical stimulus which is supplied when the bone ends are compressed together, either by weight bearing or by the tone and contractions of the muscles.

3. Finally, there are the other tissues of the limb to be considered. All the surrounding soft parts are infiltrated with extravasated blood, and with an excess of

tissue fluid resulting from the inflammatory reaction. If this blood remains *in situ*, it will eventually become organised to form fibrous tissue and will bind the structures together, resulting in a stiff, functionless limb. The only other possible fate of this blood is reabsorption into the circulation; and this process will occur only if the circulation through the limb is maintained at approximately its normal level. One of the chief features of a fracture, however, is loss of function in the limb, and loss of function results in a sluggish circulation and, incidentally, disuse atrophy of the muscles as well.

The chief aim of the treatment of the rest of the limb is, therefore, to ensure that the circulation is maintained at an adequate level from the earliest possible moment after the receipt of the injury. This can only be achieved effectively by active exercise of all the muscles in the limb, the best form of exercise being functional use. As well as promoting the rapid absorption of all extravasated blood, active exercise will prevent muscle wasting and subsequent œdema of the limb resulting from defective circulation, while at the same time it will assist in the repair of the bone itself.

The principles which should govern the treatment of fractures are therefore :—

1. Accurate reduction of the fracture and subsequent maintenance of reduction.
2. Active functional use of all the muscles of the limb during all stages of repair.
3. Immobilisation of the fracture, especially during the later stages of healing.

Reduction.—The ideal to be aimed at is, of course, perfect anatomical reposition, but this cannot always be achieved without open operation. The essential requirement is end to end contact over at least some part of the fractured surfaces. This is always preferable to perfect alignment with separation, for it not only prevents shortening of the limb, but ensures that there is a minimal gap to be bridged over at least some part of the fracture area. Excessive traction used in an attempt to correct alignment is one of the commonest causes of non-union. Once it is appreciated that union between the bone ends can take place only by the creeping replacement of the intervening fibrocartilage from the bone ends the reason for this becomes apparent.

Maintenance of Reduction.—The essential difference between "maintenance of reduction" and "immobilisation" is frequently overlooked and this oversight has given rise to much confusion of thought.

The objects of splinting a fracture after reduction are two-fold—(1) to prevent subsequent loss of reduction; and (2) to prevent movement of the fractured surfaces on one another, especially angular movement which would *not necessarily* result in any loss of reduction.

Angular movement of slight degree matters little in the early stages of repair and, in many fractures, there is little tendency for it to occur in the later stages, provided that the fracture is protected from any strains that would be likely to cause the bones actually to slip on one another. Often, therefore, the indication is to prevent loss of reduction only. Unfortunately one is too often led astray by the sequence of thought: "Maintain reduction; this implies splinting; splinting implies immobilisation; hence maintenance of reduction necessitates immobilisation"—which is not always true. For example, in the case of a fracture of the head of the radius, the best way to maintain the shape of the head of the bone would be to keep it revolving in a socket into which it closely fitted. Such a socket is provided by the annular ligament and the capsule of the joint. Hence the best method to maintain reduction in this case is to rotate the head of the radius repeatedly by pronation and supination of the forearm. Maintenance of reduction is thus effected by movement—the opposite of immobilisation.

In other situations the only likely displacing force consists in the pull of the muscles, which no form of immobilisation by splinting may be able to counteract.

Therefore, one must always be quite clear when applying a splint whether it is intended to use it simply to prevent redisplacement of the fractured surfaces or to prevent all movements at the fracture site, or both.

Generally speaking, as has been shown, it is only necessary in the early stages to ensure that no redisplacement occurs, but in the later stages immobilisation of the bones should be absolute.

Functional Use.—If it can be contrived that the patient actively uses with comfort and efficiency all the muscles of the affected limb from the very beginning, then all effusions, hæmorrhagic or otherwise, will be rapidly absorbed. Since there is then no matrix in which new fibrous tissue can be formed, no subsequent stiffness of the limb need be feared, for mere immobilisation by itself never results in subsequent stiffness in a normal limb. Further, the restoration of a normal circulation by constant muscle

activity will prevent œdema and muscle wasting and will at the same time promote rapid healing of the fracture.

It cannot be stressed too strongly that it is the first few days that count. Once organisation of the extravasations has begun there is no hope of their complete absorption, and some degree of subsequent stiffness must therefore be expected. One day of active exercises in the early stages is worth weeks of rehabilitation later. In fact, ideally, rehabilitation of the affected limb should be completed in the first two to three weeks, long before the fracture has united, and not *commenced after* union has occurred. Once a good circulation and good muscle tone have been restored and all extravasations absorbed, there is no need to fear ill-effects following subsequent immobilisation of the limb. Unless further extravasations occur it cannot become stiff, since there is nothing which can stiffen it.

There are, therefore, two conflicting aims in treatment. On the one hand, maintenance of reduction and immobilisation of the fracture, on the other active functional use of the limb. Fortunately, as has been pointed out, perfect immobilisation is not essential in the early stages, when it is so important to promote active use of the muscles; while, in the later stages, when complete fixation of the fracture may become of paramount importance, functional use of the limb can safely be sacrificed to some extent without ill-effect, *provided that early restoration of the circulation has already been achieved.*

It is now possible to outline a general plan of campaign for all fractures :—

Stage I.—Reduction.—First the fracture must be reduced and this must be done at the earliest possible moment. There should be no "waiting for the reaction to settle down," nor should gradual methods of reduction be employed, since both lead to delay in starting the next stage.

Stage II.—Rehabilitation of the Limb.—The fracture having been reduced, active exercises, in the form of functional use of the limb if possible, are instituted and persisted in until all extravasation and effusions have been absorbed, the circulation restored to normal, and good muscle tone re-established. In order to permit this treatment to be carried out some means must be adopted in nearly all cases to prevent redisplacement of the fracture. Usually some form of plaster splint is employed because this type of fixation interferes least with active use of the limb. In other cases, and especially in impacted fractures, it may be sufficient simply to reduce strain on the limb by keeping the patient in bed and arranging a scheme of exercises in which the masseuse or some weight and pulley apparatus takes the weight of the limb.

Frequently, however, it is not possible to fix the fracture adequately by any form of splint which will, at the same time, permit active use or exercise of the limb, and some compromise becomes necessary. A decision has to be taken as to how far one can safely sacrifice immobilisation in order to permit active exercises. It is in these cases that it is so important to remember that in the first week or two it is the "rehabilitation" of the limb which is of supreme importance and that so far as the fracture is concerned it is only necessary to prevent loss of reduction.

If the fracture is very unstable—*e.g.*, an oblique fracture of the shaft of a long bone—the minimum amount of splinting necessary to prevent loss of reduction may be sufficient seriously to impede active use of the muscles. This constitutes the most important indication for internal fixation of the fracture, as it is only by this means that our two objectives can be fully realised. Since internal fixation implies open reduction as well, it will have the added advantage of ensuring perfect or almost perfect anatomical reposition of the fracture, but this alone is rarely a sufficient indication for operation.

It must be stressed that the object of treatment is active use of the muscles, not movements of the joints, and that active use does not necessarily imply movement. Therefore, the mere fact that the form of fixation used immobilises certain joints does not at all imply that active use of the muscles is thereby impeded. Many muscles work over more than one joint, and if one is fixed they can be exercised over the other. Further, it is active contraction of the muscles that is required, and it does not matter whether they actually move anything or not. In many cases, even though the joint that they work on has been fixed, they will still contract reflexly and synergically when other muscles are being used, as will be explained later in the case of Colles' fracture.

By some means or other, therefore, it is usually possible to ensure that most, if not all, of the muscles in the limb can be actively used from the commencement of

treatment, while redisplacement of the fracture is prevented, even though, in some cases, it may not have been very effectively immobilised.

At the end of two to three weeks there should, therefore, be no swelling of the limb; circulation and muscle tone should have been restored, and all extravasations absorbed.

Stage III.—Immobilisation with Functional Use.—The fracture must now be completely immobilised in order to permit final union to occur, and this immobilisation of the fracture must be maintained until union is completed. Since the rest of the limb has already been restored to normal, it no longer matters if the necessary means taken to ensure effective immobilisation entail some loss of active use of certain muscle groups.

The limb as a whole, however, must still be put to some form of active function and used as much as conditions will permit. It must be remembered that the pressing together of the two fractured surfaces which results from weight bearing and from the contraction of the muscles is the main stimulus to final union.

It should be noted that although the emphasis on functional use *versus* immobilisation is different in Stages II and III, it often happens that because there is a method of fixation of the fracture available which does not interfere with the functional use of the limb, there is no need for any change in treatment between the two stages.

In order to keep the argument clear no mention has been made of any damage which may be sustained by the soft parts. Some degree of damage to the soft parts is, of course, always present, and it may be due either to the original trauma which caused the fracture, or to the bone ends themselves as they become displaced. In a number of fractures the damage sustained by the soft parts may far outweigh in importance the actual bony damage. For example, a fracture of the medial epicondyle of the humerus is caused by a lateral dislocation of the elbow, which means that the whole of the inner half at least of the capsule of the joint has been torn, which is a very serious injury. When considering a fracture it is most important to understand how it has been caused in order that the extent of soft part damage may be assessed. One must not be hypnotised by the X-ray, which only shows the bony damage, but should always endeavour to visualise the whole of the damage that has been sustained and get a mental picture of what all the structures in the limb look like after the receipt of the injury, for much the same principles apply to the treatment of injuries to muscles and ligaments, although the time periods are shorter.

EXAMPLES.

1. *Colles' Fracture.*—With a simple and uncomplicated fracture of the lower end of the radius, reduction presents little difficulty and effective immobilisation of the fracture can be achieved with a plaster which extends from the knuckles to the elbow, but does not include either. (NOTE.—This is not true of *all* types of Colles' fracture.) Such a splint will both maintain reduction and immobilise the fracture. At the same time it permits free use of the fingers and the elbow and all the muscles which work on them. Even the flexors and extensors of the wrist will be used, for they normally contract synergically with the extensors and flexors of the fingers respectively in order to steady the wrist, and they will continue to do this reflexly even though the wrist has been fixed in plaster. If the patient does, in fact, use his arm daily for all normal purposes, the ideal of full functional use during healing has been achieved, the circulation will be rapidly restored to normal and all extravasation will be absorbed. When the plaster is finally removed there will be no stiffness of the wrist, no matter how long it has been immobilised, and no " after treatment " will be needed.

This is an example of a type of fracture in which treatment can closely approach the ideals laid down. It must be pointed out, however, that even in such a case it is not sufficient merely to tell the patient to use his arm. He *will not do so* unless first shown how to use it under supervision and thus gain confidence.

Fractures of the Neck of the Femur.—The now well-known method of fixing these fractures with the Smith-Petersen nail affords a good example of a method of treatment which is 100 per cent. effective both in fixing the fracture and permitting free use of the whole limb. No external splint is required and the patient is allowed complete freedom to exercise the limb, apart from actual weight bearing. A full range of active movements is restored in a remarkably short time, even in old people. The only factor which militates against a high proportion of perfect results is the liability in old people to necrosis of the head of the femur through loss of its blood supply, and this liability is to some extent increased by inserting a nail into the already devitalised bone.

2. *Fractures of the Tibial Shaft.*

a. Transverse Fractures.—In a simple transverse fracture there is, as a rule, little difficulty in reduction, which is thereafter reasonably stable. If a full-length leg plaster is applied immediately, function of the muscles of the limb is severely restricted, even though weight bearing is permitted. There will, therefore, be a tendency to stagnation of the circulation with organisation of the extravasation and subsequent stiffness of the limb. One of my colleagues, Mr. J. S. Batchelor, has recently been trying a new technique in the hope of overcoming this difficulty. In the first instance he applies a plaster which does not include the knee, and is cut away over the front of the ankle and foot. Since a transverse fracture is stable, this is sufficient to maintain reduction. The patient is kept in bed and active exercises of all the muscles of the leg, including those acting on the knee and ankle, are instituted. After about three weeks this rehabilitation of the limb has been completed, full movements and muscle tone having been restored. Now a full-length plaster is applied, giving efficient immobilisation of the fracture. The patient is allowed to bear weight which supplies the necessary functional stimulus. In this way it is hoped to be able to avoid subsequent stiffness of the limb without adversely affecting the union of the fracture.

b. Oblique Fractures.—These fractures are unstable after reduction and traction is often required to prevent overriding and shortening. The method just described is therefore inapplicable. Traction, however, makes it impossible for the patient to exercise his leg effectively. Stiffness, muscle wasting, and a defective circulation will, therefore, surely follow. Here, then, is a clear indication for internal fixation of the fracture by plates or screws. It must again be stressed that the internal fixation is not employed primarily in order to maintain reduction or to immobilise the fracture, since this can be done by other means which do not necessitate operation. It is done in order to fix the fracture *in such a way that active exercises are subsequently possible.* It is the well-being of the rest of the limb which determines the necessity for internal fixation, not simply the treatment of the fracture itself.

TO SUM UP.

There are two main factors to be considered in the treatment of any fracture—the broken bone itself, and the disturbance of function and damage in the rest of the limb; the reconciliation of their conflicting claims constitutes the main problem in treatment. In the early stages it is the rehabilitation of the limb itself which should take precedence. Imperfect immobilisation of the fracture during this stage will not adversely affect ultimate union, provided that it is sufficient to maintain reduction. Later, however, and as soon as the circulation and muscle tone have been restored, perfect immobilisation of the fracture with the maximum degree of functional use of the limb which this will permit, becomes the most important consideration.

Opening Discussion on Trivial Causes of Sudden Death

Delivered by C. Keith-Simpson, M.D., to the Association of Clinical Pathologists at Guy's Hospital, January 29th, 1944.

LADIES AND GENTLEMEN,—I suppose the large majority of cases where death has resulted from some trivial cause are cases where the subject was already moribund from some other cause which any casual autopsy would reveal, and where death has been precipitated quite terminally by some trivial event which, were the condition more normal, might not only be trivial, but quite uneventful. From a forensic point of view, providing both causes of death are natural causes, the discovery of a precipitating cause of death of that kind quite terminally can be only of academic interest. It is not of that kind of trivial cause I want to speak. I suppose in that category we might place the terminal pulmonary emboli which lodge well down in the tree of the pulmonary vessels which, were the condition more normal, might result only in a small infarction of the lung, but when the conditions are moribund would cause death. You might also place in this same category the air embolisms to which I drew attention recently in an article on "Air Accidents during Transfusion." But these, to my mind, are not the kind of thing we have come to discuss this morning.

I should like to direct attention first to the trivial causes of death which are trivial only in the sense that they are small and, being small, easily overlooked at autopsy. Secondly, I want to say a few words about trivial functional causes of death which we can group together as deaths from vagal or vaso-vagal reflex inhibition in which autopsy will provide no indication of the cause of death.

Let me first say something about the trivial causes of death which may be so easily overlooked at autopsy and, in particular, about such causes as occur in children no more than a few weeks or several months old. These provide a big proportion of coroners' forensic problems; several times a week the pathologist doing forensic work may be confronted with a child who had died in its cot apparently smothered by the bed clothing, but who, in fact, may have died from a quite simple natural cause which is easily overlooked at autopsy. The case may appear to be one of simple suffocation and it may well seem as though there could be no other complication when a child is found thus buried with signs of asphyxia. But these cases are not the simple deaths from asphyxia which they appear to be at first sight. Hubble and Osborn have provided very good evidence to show how rapidly respiratory infections can develop in childhood—infections of the air passages which are so low in the respiratory system as to constitute bronchiolitis rather than bronchitis. A child apparently well may in the course of a few hours develop sufficient inflammation of the lower respiratory passages to cause an accumulation of fluid which, particularly during sleep, may result in the development of a progressive anoxia which eventually ends in a vicious asphyxial circle becoming developed. Nothing short of a swab examination of the lower air passages or microscopy of the lung tissue can provide unarguable evidence that such a condition existed before death. It would be most unsafe to come to any conclusion at the autopsy table, for mucus, œdema fluid, blood from asphyxial hæmorrhages and pus may eventually lie mixed together in the air passages.

There is another difficulty, for one of the *results* of asphyxiation—terminal vomiting—may take place, and inhalation of vomit may swamp the accumulation of fluids, blood, pus and œdema fluid already present in the air passages and further obscure the autopsy findings. Death from asphyxiation in infants provides a very large proportion of deaths from trivial causes. As to the frequency with which children die asphyxiated in their bedding, Thelin, from Zurich, provided some figures two years ago which showed that out of thirty cases he examined twenty showed inflammatory changes in the air passages. He did not examine these cases by swabbing and his conclusions are vitiated by this omission. He raised another bogey when he concluded that three out of these thirty cases died of status lymphaticus. I hope we agree that there is no more in status lymphaticus than that it is a constitutional condition. Whether we take the view which Turnbull and Young took that "there is no real evidence that status lymphaticus exists as a pathological entity" or whether we take the alternative view of P. H. Campbell, who regards status lymphaticus as "a condition of such lowered resistance and hypersusceptibility that the patient is in danger of *sudden death from trivial causes*. . . ." I think it must be clear that some cause of death lies in the body to be demonstrated as the cause of death. It is, in my opinion, as inexcusable to return status lymphaticus or the vascular hypoplasia which accompanies it as a cause of death as some other developmental abnormality. It is as inexcusable as giving as a cause of death some constitutional abnormality such as obesity or flat feet.

As examples of the trivial causes of death which may be overlooked in adults one could give a large number, but I only want to draw your attention to several which to my mind are most frequently overlooked because of some shoddiness in the post-mortem technique. The practice of opening coronary vessels by pushing probe-pointed scissors down the coronary vessels is almost certain to push small coronary thromboses on, with the result they will never be seen. The view of a medico-legal pathologist of some experience who has recently died, that although he had examined a mile of coronary artery in his time, coronary thrombosis was not an occurrence of any frequency, was the result of this faulty technique. I suppose the same applies in the case of pulmonary embolisms. Many of you must have seen an examination of the pulmonary arterial tree which was limited to its main branches—so that a small embolus might easily have been overlooked.

There is a practice of allowing the mortuary assistant to prepare the body to some extent, and I suppose that may be a very good practice as it saves time. I was told yesterday of two doctors and an assistant who, in a country mortuary, took nearly two hours between them with two tyre levers and a jack for the removal of the skull vault. But if something more than opening the body and removal of the skull vault

is done—if the neck tissues are loosened and the tongue is taken out and on arrival you find that the organs are lying in a pile for you to examine you will have passed the stage where you can demonstrate some of the trivial causes of death. Special technique is required to find air embolisms, and I think it is true to say that if the conditions are such that we suspect a case of air embolism we would then conduct an autopsy so that the embolism should not be overlooked. Autopsy technique should be such that it permits no overlooking of things of that kind.

I am still discussing trivial causes of death which may be easily overlooked at autopsy. There is one other condition which can be easily overlooked and of which I had two very good examples recently. Where the head is struck a violent blow—displacing it without tilting it materially—it may be possible for the spinal column to dislocate and the neck to become spontaneously reduced so that it shows no defect of alignment—nothing to direct attention to any injury in the spinal cord or even column or to indicate that spinal cord damage has taken place. I had a case three months ago of a boy who dived into a swimming-bath and who lay on the bottom of the bath unconscious, dying of asphyxia from drowning. So far as examination of the head showed there were two little rounded abrasions, one on the brow and one on the chin. Examination of the spinal column did not suggest that any material damage had taken place, but opening of the column made it clear that a transverse crushing injury of the cord had taken place. The second case concerns a man already seriously ill from influenzal pneumonia and who fell over on the way home and who was regarded as drunk and who subsequently fell again and struck his chin against a pillar-box, who was taken to hospital and who remained alive long enough to give clinical evidence of diplegia. There was no evidence from direct examination to show that damage had taken place to the spinal cord. If I had not already been given a clinical history I would have overlooked the injury. There was severe hæmorrhagic influenzal pneumonia present which would have satisfied my mind upon the cause of death, leaving the spinal injury overlooked.

There is a big group of cases, too, where, in spite of the most careful autopsy technique, no cause of death will be found. These are deaths from functional causes and can be grouped together as deaths from vagal inhibition. Eric Gardner has published a paper on this, which he read to the Medico-Legal Society last year. Gardner grouped these together as a variety of functional causes of death which result in common in a sudden cessation of respiration and circulation. There is a large group in which the sudden impact of water or foreign matter in the nasopharynx or glottis precipitates death. Spilsbury drew attention to the former in a paper published some twelve years ago. There is another group, occurring during surgical anæsthesia, especially light anæsthesia, in the course of procedure involving the vagal sheath or serous membranes, as in herniotomy or the sudden emptying of the stomach, stretching or release of the anal sphincter, passing of a urethral bougie and so on. Such stimuli may be sufficient to induce a reflex action in the nervous system of a subject lightly anæsthetised—such a reaction as might cause sudden fatal vagal inhibition.

A further group of trivial causes of death are those in which cessation of circulation and respiration by vagal inhibition is induced by painful stimuli, in particular of the serous membranes of the chest and the abdomen following exploratory entries into the pleural sacs and the abdomen, more especially in subjects who are unduly nervous and whose reactions towards such stimuli would be correspondingly exaggerated. (I had a case in London where a man who had had a puncture exploration of his pleural cavity said to his father, "If they needle me again I shall die"—and he did; before the needle had entered deeply enough to pierce the pleural sac he had died quite suddenly. He was fit at one moment and dead the next, and was an example of such deaths.)

Many cases of manual strangulation are unintentional deaths which had taken a very short time indeed and are not deaths from asphyxiation, which would take at least some twenty to thirty seconds to develop, but deaths virtually instantaneous. There is other evidence to show that these deaths are unintentional. A grip on the neck so effected to prevent shouting for help may result in death because of such a vagal inhibition.

Deaths from such causes would result in autopsy findings which literally amounted to nothing, and it would be only by discussion between those who were responsible for the clinical observations before death or by reconstruction that one could arrive at the conclusion that death was due to vagal inhibition. The normal autopsy technique should, then, be such as will ensure discovery of such trivial causes of death as *are* discoverable—or we shall be talking of status lymphaticus.

Sport

Rugby

GUY'S *v.* ROYAL NEW ZEALAND AIR FORCE.

Result: Guy's, 11 points (1 goal, 1 penalty goal and a try); R.N.Z.A.F, 13 points (2 goals and a try).

One shudders to think what the score might have been against Guy's had the New Zealanders been able to get the ball from the set scrums. As it was, Lee hooked so well that the number of times the New Zealanders got it could be counted on the fingers.

Guy's were slow in making use of this advantage. The ball came out slowly from the base of the scrum, and the whole back division was slowed up in consequence. All the New Zealand attacks came from a quick heel in the loose and some smart work in the line-outs, which brought them ten points in the first half. The first try by Hewitt, their scrum half, was from a scrum on the Guy's line, and the second was scored by Grant following a pick-up from a loose ball, both tries being converted by MacDonald. Gullick reduced the deficit with a penalty goal just before half-time.

The game became more exciting and Guy's woke up from their lethargy. Scrums for line-outs was the order, but their best rallies came when Dwyer went off for the rest of the game, and Ziervogel was temporarily off on the touch-line. Hilliam scored an excellent try from a forward dribble which Gullick converted, and Jones was in the right position to take the ball from a punt by Hewitt, and racing hard for the line from half-way scored in the corner.

Having taken the lead Guy's repelled all the New Zealand onslaughts until Grant got away in the last minute for an unconverted try. True, Guy's fielded many reserves owing to injuries, and their performance may be considered creditable, but unless something is done about the back division much of the good work of our excellent pack is wasted. No doubt the officials are fully alive to this problem.

Team.—E. K. Harris; D. R. Edwards, P. J. Dwyer, D. G. Jones, D. C. Boyd; E. W. Graham, R. N. H. Vann; I. H. Hilliam, A. B. Lee (captain), R. A. Dean, C. Ziervogel, D. L. Gullick, P. S. Carton-Kelly, C. Vidot, S. M. Hilton.

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION.

February, 1944.

Pass.

P. Brightwell
E. H. Couper
M. E. Evans
J. M. Fabricius
C. O. Fung-Kee-Fung
G. W. Garland
A. B. Lee
L. G. C. Martin
J. K. Morgan
W. S. Morgan
A. M. Rajah
D. R. S. Saunders
I. T. The

Supplementary Pass List

PART I.

R. F. Barclay
M. D. Cremin
A. B. Dickie
F. R. S. Knight
B. Stoller

PART II.

R. Finney
P. W. T. Hollis
L. P. Ribet
J. C. P. Weber

PART III.

R. A. Allen
F. B. S. Barkworth
J. Fry
A. J. P. Graham
H. A. Philcox
D. A. Tait

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FINAL EXAMINATION.

February, 1944.

PART I.—Surgery.

A. J. Bridge
K. H. Brown
A. C. Campbell
J. W. Coombs
H. E. P. Grabaskey
P. Griffiths
P. C. Hanley
F. B. Hickman
R. E. Hyman
J. R. James
G. E. Johns
K. M. Little
C. S. Matthews
D. S. Nelson
A. D. Robinson
H. I. Tozer
M. G. Trott

PART II.—Dental Surgery.

J. Bachner
T. T. Billington
N. P. Bronsdon
P. C. J. Crisp
A. J. R. Davies-Evans
J. H. Farrell
W. R. Hall
R. J. Hart
J. C. Howe
D. T. Humphris
R. E. Hyman
L. J. Leggett
A. D. Robinson
B. H. Taylor
D. E. Williams

Casualties

Wounded.

Surg.-Lieut. J. C. Bulstrode, R.N.V.R.

R.A.F. Appointment

Air-Commodore C. P. Symonds, C.B., has been granted the acting rank of Air Vice-Marshal while holding the appointment of Consultant in Neuro-psychiatry.

Deaths

EYRE.—On February 17th, 1944, at Ivy Hatch, Sevenoaks, John William Henry Eyre, M.D., M.S., of Portland Place, W.1, aged seventy-four years.

FAWCETT.—On February 18th, 1944, at a London Nursing Home, John Fawcett, M.D., F.R.C.P., 21, St. John's Wood Court, N.W.8, aged seventy-seven years.

STANSFIELD.—On January 25th, 1944, Tom Stansfield, M.B., B. S .(Lond.), of 120, Oxford Road, Reading, aged fifty-seven years.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE *Gazette* has always had two Editors and it has been customary to alternate in producing that editorial bugbear "Passim," and to do so independently. It would be remarkable should views expressed coincide in every case, yet usually the subjects are not of a sufficiently controversial nature to involve sharp contradictory notes from time to time. Recently, however, a distinctly controversial issue has been brought to a head—the White Paper. Frankly, on this we disagree. The answer—to adopt the view of the so-called senior Editor ?—to produce a joint effort ? The former seemed foreign to our principles of open-mindedness ; the latter refused to work. So why not each discuss it and hope to be excused for inconsistency on the plea of an effort to sustain impartiality ?

The proposed National Health Scheme demands two basic changes—that a larger percentage of the national effort be devoted to the maintenance of health and the care of the sick, and that central control be increased to ensure that this effort is concentrated in proportions adequate to meet the varying demands throughout the country.

On the first count the profession must surely accord whole-hearted support. Even before the War, when to talk of the profession becoming overcrowded was the fashion, the life of the general practitioner was one long endeavour to catch up with the work to be done. Those remaining in practice now are even more certain to give their approval. Yet, at risk of being guilty of fantasy, we believe even this can be overdone. To take the comparatively narrow view, may we assume that following these Anarchistic years of war the World State will not be accomplished and competition 'twixt countries will remain ? It is regarded as heresy to express doubt as to whether this war is indeed a war to end wars, yet allowing that man may have advanced sufficiently to stifle such blatant strife, trade warfare must persist ; the fittest will still survive, though fitness may take on new shape. Now National Energy will itself grow by devoting a proportion of itself to National Health, but a time must come when the optimum ratio is passed and the nation decline in the international struggle. It is, of course, ridiculous to accuse the Government of such tendencies, yet an unguided public might well overrun this point from untutored enthusiasm.

Let us for a moment verge on the Wellsian and consider a united World State planning its health and social schemes for the care of the sick and the mentally deficient, unduly fostering the parasitic elements—where man's success as a species is in jeopardy and eugenic principles show the only road to renewed success. But this is before its time and we have probably wandered into that new age when men cease to be men but scientists.

But it is on the second count that our disunity is apparent. How far is it permissible to allow bureaucratic control to go without virtually robbing yet another section of the community of their individuality ? May this not be a step towards that from which everything in our history recoils—the omnipotence of the State ? Should this sacrifice be made if it is in the interests of the community (itself a debatable point) ? To the first we can find no brief reply. On the second the nature of our journal forbids discussion. For the third we suggest of those who would have it so that mostly they are either inhuman or hypocrites.

WE regret to hear of the death of Mr. Tilley, who was for long employed in the Works Department. For some years he was a carpenter and later became foreman. During this period he often enabled the medical staff to put some new idea into operation by his great ability to grasp what was really needed and to produce the required article. Mr. Tilley had retired a few years ago, but remained a loyal supporter of the Hospital. His death was sudden but happily peaceful ; he died as he worked—at Guy's. We offer our deepest sympathy to his relations on their sudden bereavement.

Obituary

PROFESSOR J. W. H. EYRE, M.D., M.S., F.R.S.E.

THE passing of Professor J. W. H. Eyre, at the age of seventy-five years, deprived both Guy's and bacteriology in England of a noteworthy figure. "Johnny" Eyre first entered the Medical School at the age of twenty and, in minimum time, qualified M.R.C.S., L.R.C.P., and graduated M.B., B.S. in Durham University. At this stage he had decided to specialise in ophthalmic work and was appointed ophthalmic assistant and registrar, devoting his attention, under the influence of the then bacteriologist to the Hospital, Dr. Washbourn, mainly to infective eye conditions. So interested did he become in the bacteriological side and so skilled in the rather immature technicalities of those days that, following an excellent paper on the bacteriology of the normal conjunctiva and a classical description of tuberculous conjunctivitis, he decided to change over to the new laboratory science and thus entered the field when bacteriology as we know it to-day was in its infancy. In 1899 he went to Charing Cross Hospital as bacteriologist and lecturer, and then, three years later, after holding the first Ernest Hart Memorial Scholarship, returned to Guy's to succeed Dr. Washbourne as bacteriologist to his own hospital.

From then onwards his rise to fame was meteoric; in the first part of the century everyone who knew Guy's knew Eyre. Starting work in cramped, unpromising quarters his activities and his department grew with remarkable speed. His pioneer work consisted in devising a host of technical methods, many of which survive to this day and at the time his "Ele- ments of Bacteriological Technique" was the stan- dard work. Recognition of his exceptional laboratory skill soon followed, and in 1905 he was co-opted by the Royal Society to the Ad- visory Board of the Commis- sion on Mediterranean Fever and acted, where one might expect to find him, in Malta as chairman of the actual working party. By the time he returned it had become recognised that bacteriology was acquiring ever more clinical applications, and the Governors of Guy's wisely decided to develop a first-class department, giving Eyre an entirely free hand in its design. This first Bacteriological Department, situated between the Super- intendent's Office and the Chapel, functioned for exactly twenty-five years and met every demand made upon it. Number- less Guy's men well remem- ber it as one of the show laboratories of the Hospital and a place to which all visitors were taken and, if specially favoured, allowed to switch on the various little electrical shakers, viewing boxes, day-light lamps and other gadgets with which it abounded. But behind these superficialities lay an organisation so well designed both as regards records, staff duties and accounts that it has not only served as a model for very many laboratories up and down the country, but also itself completely withstood the test of time and, efficient as ever, had required the minimum of change by the time Eyre retired in 1934, a great tribute to the remark- able foresight of the designer. With the new department came greater activities on the part of its chief. His spheres, his plans and his motor-cars became ever larger. He was Erasmus Wilson Lecturer and a Hunterian Professor at the Royal College of Surgeons and Milroy Lecturer before the Royal College of Physicians. Having held a readership in his subject for many years, the title of Professor was conferred upon him by London University in 1920, and meanwhile, as as examiner, he had acted for his University in State Medicine from 1901–1905 and in bacteriology from 1923 to 1928. For the Royal College of Surgeons he examined in public health from 1917 onwards and in tropical bacteriology from 1911–1920. At scientific meetings his minute trim figure was known everywhere, and either at those or in administrative committees he was a first-class chairman. Perhaps his best known activities in this direction were his presidency of the Section of Bacteriology and Pathology at the Annual Meeting of the B.M.A. (1913); the Royal Microscopical Society (1920–1); of the Hunterian Society (1939–42); and the Royal Institute of Public Health and Hygiene (1942).

Abroad he was relatively well known and is recorded as an active corresponding member of the Société de Pathologie Exotique and the Société de Pathologie Comparée.

and produced a very fine revised English translation of the " Experimental Bacteriology" by Kolle and Hetsch.

Having devoted his earlier days to purely experimental laboratory work, the natural advance of his subject into clinical spheres tended to carry him with it and his earlier work on the varieties of pneumococci causing pneumonia and the association of the Flexner strains in institutional dysentery was followed by a long period of intensive study of the effects of a great variety of vaccine and serum treatments, summarised in an excellent little book, written with Dr. Bosanquet, on " Serums, Vaccines and Toxins in Treatment and Diagnosis." At this stage came the inevitable closer association with practical medicine and the development of a considerable private practice. Thus most of his more recent writings concern the applied rather than the technical side of his specialty. It is true that in the latter he first became famous and will remain a recognised pioneer, but those who worked with him in more recent years at once recognised his equal skill when man and not the experimental animal was under observation. One side of his purely observational work he did, however, continue to the last. For a great many years he was Bacteriologist to the Worshipful Company of Fishmongers, and in that capacity produced a beautiful series of reports upon the disease-carrying properties and purification of the various edible molluscs, particularly the oyster and the winkle. This work seemed almost to be a special hobby of Eyre's and few hobbies can have been so useful in the cause of human health.

Meanwhile, throughout the whole of his long career, he was a very prominent Freemason and reached very high office. His energy was apparently inexhaustible and at no time was he not concerned with something that, whatever else it might achieve, involved the hardest of work. Nothing would ever persuade him to retire and he died, as he had lived, in harness. When he retired from Guy's, receiving a quite famous farewell dinner, it seemed that he would take some well-earned rest, but instead, after deciding to live in the country, not far from The Wildernesse, he began to return almost daily to town, organised a private laboratory of his own and was at the end experimenting upon schemes for killing infection possibly imported by aeroplanes !

The affection and respect which everyone at Guy's held for " Johnny " Eyre is, perhaps, best learned by consulting the *Gazette's* own columns. With his minute size and dynamic energy, he was the student caricaturist's joy. Different periods throw different shades of light on the character of those about the Hospital, but rarely has anyone so continuously held the friendly esteem of everyone as did the man who has now left us, so small in stature yet so great in personality and achievement.

Fear and Pregnancy

A Clinical Lecture delivered by Harold Chapple, M.Ch., F.R.C.S., at Guy's Hospital, on Thursday, February 24th, 1944.

GENTLEMEN,—The problems you will meet in obstetrics and gynæcology depend for their correct solution on a knowledge of the organic and psychological factors involved in them. The organic side receives much attention, and those of you whose experience is unfortunately obtained to-day largely by watching in the operating theatre and not from the far more important work in the Out-patient Department may arrive at the erroneous conclusion that gynæcological conditions consist largely of abdominal tumours and prolapses. The psychological side, on the other hand, receives far too little attention, and I cannot urge on you too strongly the wisdom of taking every possible opportunity of attending Out-patients' and becoming familiar with the common problems that are to be met there in abundance. You will find, too, that text-books on obstetrics and gynæcology make little reference to the psychological aspect and certainly do not emphasise it. To help to remedy this serious omission I am focusing your attention on it to-day.

In the psychological group the several emotions are included, but as I cannot deal with all of them to-day, I shall lay particular emphasis on the part played in pregnancy and in many gynæcological conditions by one of them, namely fear, and shall point out that this fear may originate in the patient's own mentality and circumstances, but also may be implanted by a lack of sympathy, knowledge and understanding on the part of the doctors or nurses who are attending her, with results that may be most unfortunate.

I suppose one's early impressions tend to remain rather vivid, and I was made aware of the importance of the mental aspect of my subject by an early experience of working as clinical assistant to a gynæcologist, whose chief aim appeared to be to get his out-patients examined in record time. If they had some definite organic disease that called for radical surgical treatment, the operation indicated would be performed by him with considerable skill; but, if not, their stories were brushed aside as uninteresting and the unfortunate women forthwith dismissed, with no attempt having been made to investigate their symptoms further, or to deal with them in any way. This appeared to me to be a very serious omission; in actual fact only a small proportion had benefited from their visit to the hospital.

A little later I was instructed by an ardent young physician, tremendously sure that he had reached the end of knowledge, even at his tender age, and who was inordinately proud of a long index finger with which, he assured us on several occasions, he could always detect by rectal examination an intussusception in a child. I saw this performance once, and it reminded me strongly of pinning out our early friend Lumbricus, the loathsome earthworm, on a board preparatory to dissecting him. I realised that the diagnosis was likely to be correct eventually, as if the poor little child had no intussusception to begin with, he almost certainly would have one at the end of the examination. The distress of the child left this physician completely unperturbed and he never appeared to understand why the child was terrified whenever he subsequently approached the bed. You will agree that vigour amounting almost to brutality is not essential for a successful rectal examination, but, on the contrary, it may do the patient grave harm both mentally and physically.

These experiences I followed by a few months as assistant in a Berlin hospital, where the patients accepted their rough handling with that dull docile servility of which only Germans are capable and to which only they would submit. An indelible impression was thus made upon me and I realised the necessity of understanding the patient's mind and feelings as well as her organic condition if one wished to be a successful practitioner of the art and science of medicine.

In this lecture I am using the word "fear" to imply a state of considerable anxiety, due to impending danger and not of cowardice, and in the cases and conditions we are discussing you will observe that there is often no real ground for such fear at all; nevertheless, it may be a major factor in the production of the symptoms complained of or even the sole cause.

A while ago a patient consulted me for a lump which she had noticed protruding from her vulva. This discovery had horrified her, and—as is so frequently the case—she had kept it a secret until she could no longer do so. I noticed that she looked harassed and ill and was clearly greatly anxious about herself. Now, uterine prolapse is a mechanical condition which can only produce this degree of general ill-health by some such late sequel as back pressure on the urinary tract or its infection, or by the fact that the exposed membrane had become ulcerated and infected or even followed by malignant disease. Investigation showed that there was nothing of this kind, but that the patient was convinced that her condition represented "cancer," and, as it was in that region of the body, she was convinced it must be of a very unpleasant type, as her mother had died of "cancer of the womb." This wrong deduction, with its sequelæ, was the real cause of her major symptoms. The plastic operation which we perform daily for the cure of prolapse is now almost invariably successful, as you know, but that in itself would not have cured her of her fear and so her relief would only have been partial had it not been explained to her that the condition had nothing whatever to do with cancer. On removing her fear the change in her well-being was remarkable. You may retort that hers was a peculiarly stupid deduction, but let us be more humble and realise that a great many beliefs that we ourselves hold are just as stupid and as far removed from reality, though we are often very certain of our own infallibility and prepared to defend our convictions with vehemence or even violence. There does not appear to be any limit to human credulity from the native in the mud-hut to the prelate in the palace. How much of this do you think is reaction to fear?

You will all, of course, become very familiar with the patient who is certain she is pregnant, but is not. In her this fear or belief may produce almost any symptom that she regards to be the necessary accompaniment of pregnancy. So familiar am I with this that "symptoms" and "feelings" do not influence me greatly in making the diagnosis of pregnancy. A patient from whom I had removed both tubes for a salpingitis used to come to Out-patients to ask to be attended in her confinement, and would give a detailed description of the movements of her child which kept her

awake at night. She would not even believe that she was not pregnant when refused the desired attendance card, but persisted in pointing to her relaxed abdomen and her definite feelings of the child's movements within it. She was very afraid that the child would be malformed by the previous operation. How much do you think this had to do with her condition ?

During pregnancy you will find a number of women complaining of symptoms that bear no resemblance to reality. In them a protective maternal instinct is highly developed, and the symptoms are produced as the result of a common fear revealed by the conversation of chatty ladies whose sadistic tendencies would appear to be stimulated by descriptions of imaginary malformations and tragedies which they assert have occurred to their certain knowledge. Then, if their story does not appear to convey conviction, they are even prepared to go further and to say that they know the individuals personally. There are few who advise more readily on the trials of pregnancy and labour than elderly spinsters.

In those distressing cases of the toxic vomiting of pregnancy that you will sometimes meet, the organic or toxic, and the psychic or so-called functional, are closely interwoven. In these, too, you will find that fear plays its part. The patient's outlook is greatly influenced by the knowledge that several of her friends have gone through pregnancy with nothing but joy, and never felt better. Why, then, should she feel so constantly sick and ill ? There must be something radically wrong ! It has been recognised for at least a hundred years that there is a large psychological element attached to this condition—though this does not explain the whole picture. Now it is not given to all of us to possess the commanding personality and charm of manner which will persuade, in a few brief moments of conversation, every lady who looks ghastly and will persist in vomiting repeatedly in your presence, to abstain abruptly from this revolting practice and accept with alacrity an invitation to lunch *à la carte* ; and so you will have to fall back at times on other methods of treatment. The mere designation of the condition as functional will certainly not always cure the patient ; on the other hand, removal of the element of fear will often be of considerable assistance to the patient. I wonder how long it will be before we act on the realisation that giving a name to a condition—especially a Greek or even a German one—is not the same thing as clearing up its pathology or discovering its treatment.

Cases of dysmenorrhœa will provide you with ample material for thought and skilful observation. They include in their ranks a great variety which range from cases of severe real pain whose cause is not yet understood, to those which have a preponderating psychological basis, in which you will notice that fear at times plays a large part. A mother brings her daughter to you and opens the proceedings with : " Now, you're not going to be one of those stupid doctors who says that no girl gets pain at her period. Look at me ; I've had it all my life, so I have told my darling that she, too, must expect it." In line with modern nomenclature this might be described reasonably as a case of *matropathia*. (Some of you may remember a perfect example of this kind we had recently in the ward ?) Again, this was brought vividly to my mind early in my experience by the father of a patient who came to see me about his daughter and, incidentally, taught me a great deal. The onset of each of her periods had steadily increased in importance to ranking almost as a local catastrophe in his village. Blinds were drawn, servants tiptoed through the house, visitors came to enquire and brought suitable flowers and fruit—and so on, until he began to find this a little tedious. His observations had led him to the conclusion that fear was a large factor in her condition. We confirmed this, and when she was convinced that the pain—which she had noticed was inconspicuous in other girls at school—did not indicate such serious pelvic disease that she would be rendered unsuitable for the life of a married woman, the condition rapidly cleared up and cachets of phenacetin and aspirin completed the cure. Now, I do not intend to imply that fear is even the chief factor in all cases of dysmenorrhœa—far from it ; but I have found that a wrong interpretation of the pain is an important factor in many of them, and in such cases to suggest heroic measures such as the division of the pelvic sympathetics is not exactly intelligent. I have been led to wonder if the operation is suggested as a treatment or a punishment.

How many times at Out-patients' you will write down detailed notes of great pelvic pain, and nothing organic be found on examination that could possibly account for it. The explanation will often lie in the discovery that this is a defensive reaction against married life or the fear of further pregnancy. In fact, with certain peculiar beliefs it is the only possible escape from an impossible position. If you hold the opinion that

the majority of married women are thrilled at the prospect of rapidly repeated pregnancy, you will fall into serious error. The poetic story of the "girl who leaps with joy at the feel of the child within her womb" is like so many stories, which may be entertaining at first, but are apt to pall a little after frequent repetition. To those, then, who are banned from the use of a scientific contraceptive, there only lie open the methods of developing a pelvic pain which is either fictitious or due to the frustration of those sexual appetites which have been implanted in them but with which they cannot cope, or the miserable subterfuge of depending upon an entirely fallacious "safe period." My operative and clinical observation over years have shown me that, contrary to the belief accepted at present, the shedding of the ovum does not bear a constant relation to menstruation, but is variable in the human and that pregnancy can supervene at any time in the month.

I hope I have now provided you with a number of illustrations to show the important part the emotions illustrated by fear can play, and that their recognition is very important for successful understanding and treatment. You can confirm the truth of this statement any day by your own observation. Let us now pass on to the obvious corollary—namely, that we must be exceedingly watchful lest we ourselves induce fear either by careless word or unthinking behaviour. Does this seem self-evident? I hope so—and yet it is done many times every day, and often with serious consequences. Their actions justify my belief that many people do not realise this in the least, and so I draw your attention to it. Think for a moment what must be the effect on a sensitive woman, with no knowledge of her own anatomy, of receiving such cheery pieces of information as: "Your womb is out of place," "Your kidney is dropping," "You must give up all idea of having another child," and so on. These remarks may leave a permanent scar and do not come only from the idle and unemployed, but are often thrown out as the emanations from the great brain of a "very careful doctor," after a series of investigations in expensive clinics designed for this purpose. You will notice, incidentally, that this process of investigation in a home elaborated for the purpose may at times do some good, but wrongly used, can be productive of immense harm and should be used with great care and discretion. I have seen patients who have not recovered from their experience for years. They had very little the matter with them when they entered the imposing portals, but a good deal when they came out, and for this they had often paid a great deal of money—was it as a thanksgiving offering? This was a popular pastime among the clinics of Germany and their imitators in this country. Yet could anything be more unbalanced? If you cannot produce a remedy, why tell the patient and frighten the life out of her. For example, I have often seen patients literally terrified because they have been told quite early in their pregnancy that they have a rather high blood pressure. This with the air that a great, if not welcome, discovery has been made, to be followed by the casual information that later on the child may have to be removed. There is such a case in Pembury at the moment. A woman of thirty-seven, who feels perfectly well and would be delighted to be pregnant, but she has been told that her blood-pressure is high. The effect on the unfortunate woman has been marked and much unnecessary suffering has been already inflicted. In any particular case it is not possible to prophesy the course of events, but in many cases very often nothing untoward will happen at all, the condition being of little immediate importance and, in any case, there is very little adequate treatment, so what conceivable benefit can there be in terrifying the patient?

After pelvic operations much harm is still done by doctors and nurses whose excessive and unnecessary care leads the patient to wonder what on earth has happened to her. She feels well in herself and is anxious to get on with her life again, but apparently she is not supposed to—otherwise, why all this fuss? In nothing will you find commonsense more necessary than in the treatment of a patient during convalescence. How many times will you meet with a patient who has been subjected to a simple hysterectomy full of apprehension about her future, though she will not always admit it. You should always explain the implications of a pelvic operation, otherwise the patient's information will be derived from one of those delightful females whose lack of knowledge is no bar to a free expression of dogmatic opinion, that this "ghastly operation" will render her at best completely unfit for the intercourse of marriage and at worst for a lengthy sojourn in a home for the insane. There is happily not, of course, a word of truth in this, but there is nothing original in it either. You will find in life that the person who knows most almost invariably talks least. These things would be unimportant but for the fact that the implanted fear often retards

recovery for a long period, whereas all that was necessary for a complete recovery was a simple kindly explanation that the cessation of the menses does not induce insanity; that the continuation of her married life is not now barred to her; and that she will not become masculine and grow a beard and smoke cigars or develop some other strange tendencies.

During the span of my responsibility at Guy's the method of treating cases of disproportion and obstructed labour has turned full circle. At first, in the earlier days when obstetrics was a sport carried out on the district by a pack of students whose methods were strongly reminiscent of the game of Rugby, the patient was submitted to what was known as a "trial trip," which was often terminated by a trial of strength known scientifically as the application of high forceps, but in the language of that day as the "clapping on of tongs." These rough-and-ready methods, ingenious in some ways, were later gradually superseded by the more frequent induction of premature labour and Cæsarean section. Now the method of trial labour has returned to favour, and I think very often rightly so—but do not let us ever forget that we are not dealing with insensitive robots, but with human beings on whom these experiences often leave an indelible mark from the horror and fear experienced. Is it to be wondered at that a one-child marriage frequently results, with all that it implies? From my early days I have endeavoured to work out a perfectly safe method of countering the pains of labour and the consequent fear for those in need of it. So far I can only claim partial success, but it is, in my opinion, important work and well worthy of all your efforts to improve.

Again, some of the most difficult cases you will be called upon to handle are those which are grouped under the condition known as primary inertia, and in the treatments outlined by the experiences of your predecessors you may often notice a complete absence of regard for the fact that you are dealing with human beings. The stated guiding principle is to leave things to Nature. Excellent—provided Nature is reasonable and makes demands on the patient that are supportable, but you must take into account that the limit of endurance varies considerably in different people, and a prolonged tedious labour lasting for three or four days is not tolerated by some people without considerable lasting injury; whereas others will not only endure it, but make light of it. The later stages of these prolonged labours are greatly affected by the fear engendered by the patient's own instinctive deduction that progress is halted and that they are incapable of further effort—and so their general condition rapidly deteriorates and disaster approaches.

I hope you will agree that I have now provided ample illustrations from my personal experience to prove the close association of the organic with the psychological, and my object in doing so was to draw your attention to that side which is so often neglected and yet is so essential. The organic side is simple and obvious, *e.g.*, if a woman has an ovarian cyst, she must have it removed or it will remove her. But it is the estimation of the importance of the emotional factor that will present you with your real difficulty; so, to-day, I have not brought you a discourse on a very rare condition which you may never see, but have come down to earth and directed your attention to plain common things—so plain that they are often completely missed. If I have succeeded in attracting your interest I shall feel that our time has not been wasted. Causes and symptoms are so readily confused; and let us always remember with due humility that the most experienced among us can be wrong. So much can be missed in an unremitting pose as scientists, and so much real help given by the constant awareness of ordinary things.

Another Letter from "Sinbad"

MY DEAR BILL,—This should reach you at the end of your first trip. I wonder where it has taken you? I don't suppose you will read it until you have got through the jumble of bills, belated Christmas-cards, *B.M.J.s*, love-letters, etc., which will be deposited in the wardroom for you by the postman on the day you arrive. It is a big moment when the seven or eight mail bags are brought on board and the fannies (mess tins) are filled with letters and everyone is reading about the real world from which he has been temporarily exiled.

There is a fundamental difference between Military (those poor bloody pongoes, as the sailors term them so delicately) and Naval medicine; the former is excremental, the latter elemental. This sounds obscure, but military medicine starts by digging

latrines, while the sea, solving this problem for us, immediately presents one even more puzzling; wind and weather arbitrate in all maritime enterprises and medicine is no exception to this rule. It doesn't need to be very foul for a small ship to make some astonishing rolls; the other day was quite calm, but for no good reason the ship suddenly rolled about 30 deg. This meant that a man on the bridge moved about twenty-five feet from one end of the roll to the other. We were at tea at the time and our Canadian officer remarked that it would sure cause a stir at home. Ashore it seems hardly credible that the table at which you are sitting should behave like a see-saw, but at sea in a small ship it is quite usual. Therefore, as a preface to all minor medicine and surgery afloat, you start by planting your feet firmly on the deck or sitting with your feet splayed in a well-secured chair, wait until you can judge the rhythm of the roll and keep your proprioceptive receptors on the look-out for a change in that rhythm.

It is best to work out a series of standard treatments and teach these to your S.B.A. The most numerous injuries are those of the hands. The usual approach to the cut finger is for the injured man to say to the S.B.A.: "I say, Doc."—(your S.B.A. is always "Doc." to the ship's company, while you are the "M.O." or "the Quack)—"what about a bit of plaster for my finger." He then exhibits a filthy finger with sticky blood congealing round the cut. I made a rule that all fingers must be washed in hot water with plain soap for five to ten minutes. The stupid and dirty men (a very small minority) must be supervised by the S.B.A. At first this was considered eccentric, but now it is done as a routine. The incidence of sepsis has been very low. For hand injuries in general I use Mark Iselin's book; it goes into the operative details which are so often omitted. His "ring" local anæsthetic is admirable. I do not possess a satisfactory operating couch, so have to do these finger injuries and whitlows with the patient sitting up, but if you give him a book to read and a few cigarettes he is usually quite happy. Injured toes can be treated by the same method.

I have pondered a great deal over the problems which face the single-handed surgeon anæsthetist. The dramatic picture of the first lieutenant giving the anæsthetic and the doctor doing the surgery is not very reassuring, although it has occurred on a number of occasions. The literature which I have secured is pleasantly vague on the subject, although the would-be surgeon is always warned that, when using the intravenous barbitrates, he should not be his own anæsthetist. So far the most hopeful line I have discovered has been that of the Russian surgeon Vishnevsky, whose local anæsthetic technique might have been evolved for the single-handed surgeon. This method about which I am at present trying to get exact details consists of deep infiltration with large quantities of $\frac{1}{2}$ to $\frac{1}{4}$ per cent. procaine. It is claimed that this reduces shock and allows early transportation; it could clearly be combined with intravenous barbiturates, and its use with oral hexobarbitone has been described. The difficulties of nursing a patient on board ship are sufficient without the addition of post anæsthetic vomiting upon which seasickness would certainly be superimposed.

There is very little advice for the newly qualified man working on his own whose previous experience may have been six months or less of house jobs. In books on emergency surgery the presence of anæsthetist, operating theatre and surgeon appear to be the basic assumptions of the writer. The R.M.O. is advised to get his man back to the specialist units as quickly as possible and in as good condition as possible, but at sea this cannot be done. The official attitude savours somewhat of benediction rather than salvation, "Do your best, my boy." What is wanted is a series of descriptions of typical operations done in unfavourable conditions with an analysis of results and advice as to how various typical failures can be avoided.

For instance, the classical surgical emergency is acute appendicitis; in my own ship, in the last commission, one was done with great success—the weather being foul and U-boats in the vicinity. It was a fine piece of work. I had one myself, but was luckily able to get the patient on after a tricky and anxious twenty-four hours. Having heard Mr. Brock's sombre and admirable lecture upon this subject, I shall always remember his solemn warning that physical signs give you very little indication of the pathological condition of the appendix, but I should like his opinion upon the relative dangers of Fowler's position, massive sulphonamides and local heat, conservative treatment and amateur operation, under unfavourable conditions with an unstable platform both for the surgery and after treatment. I have had to weigh up the chances myself, the situation is complicated by the fact that the majority of your shipmates will be in favour of operation since the general lay opinion appears to be that any doctor can do an appendix. Now while it is true that an appendix was removed by an unqualified pharmacist's mate in a submerged U.S. submarine, using the spoons as retractors, a

Guy's man whom I know to be a highly capable doctor, tells me that after an operation at sea upon a patient who subsequently died, he would favour the conservative method method. It is most unfortunate that there is no review of the subject covering the special circumstances encountered afloat, because at the moment the opinion of those doctors whom I have encountered has been that while encouraged by some splendid successes there is an uneasy feeling that there must be some unpublished failures. *Appendicectomy is not an operation to be undertaken lightly by surgical amateurs.* I must now leave the surgical field to the surgeons, begging him before the war is over and before the helicopter and peace make him extinct to think of a few wise words for their humble isolated brother.

One point: you will find that suturing and cleaning wounds, especially facial wounds, is much easier if a little 1 or ½ per cent. local is infiltrated round the edges. At sea there three moveables—you, the patient and the ship; if to these three are added involuntary jerks and starts by patient even simple suturing can be extremely tiresome. It is odd, but I believe that the most grateful patients are those who have had stitches put in, especially facial injuries. Stitching has an especial fascination for the victim and onlookers, and the former derives pleasure both from the number of stitches required and benefit obtained. Your needlework will be held in high esteem.

Even in a small ship there are always a number of psychiatric cases ranging from mild anxiety states and anxious personalities who need talks and reassurance to acute panics and psychotics. The latter include dull men of low intelligence for whom there is no more place in a small ship than with the commandos. It is cruel and dangerous to allow this sort to go to sea and they should be sent to a psychiatrist. If one of your brother officers tells you of some odd and queerly behaved individual be sure to see him as soon as possible and take a detailed work history. Lately I had one strange chap who had had forty jobs in the last four years; he had only put down four on the form because there was not enough room for all his occupations. Middle-aged men who suddenly volunteer for sea service should be also closely watched. Patriotism would get a man in from 1939–42, but sudden decisions by a person in a reserved occupation to join the Forces require some looking into. The opportunities for conscious or unconscious suicidal acts are so numerous in a ship and so likely to involve others that psychotics should be sent ashore without delay The psycho-neuroses are easily divided into those who can carry on with their work and those who cannot. The latter require hospitalisation, since idle and, to their messmates, healthy men have a bad effect upon morale. This leaves numbers of mild cases who respond excellently to simple therapy and exploration of symptoms with discussion of their various problems with generous sedation with barbiturates when necessary.

I have had no malingerers, but old George, who was a R.M.O. to an infantry battalion until he became a paratroop, tells me that in training he would have a great queue of men outside his sick quarters before route marches, until he had a special lorry to take those with no marked illness and drop them some distance behind the main body with an N.C.O. to see that they caught up. The reason is probably a combination of the high quality of naval personnel and the fact that a malingerer can get off very little in a small ship. He may be put in his hammock (but the malingerer usually aims at escaping some specific duty) or put on light duties in the mess, but the conditions in the messes are such that few would wish to be confined in them all day and, being under the constant surveillance of his messmates upon whom the burden of his absence must fall, deception is unlikely to escape their critical notice.

I remain yours,

Ever smiling with the knife,

"SINBAD."

H.M.S. *Verucca*,
c/o G.P.O.,
December, 1943.

Sport

Hockey

INTER-HOSPITAL KNOCK-OUT TOURNAMENT.

Winners: Guy's. Runners up: St. Mary's.

First Round.—Guy's, 4; Westminster, 1.

This game was played on January 15th at H.O.P.—a day of thick fog. When the teams met at the ground visibility was about ten yards. We had just decided that play was impossible when fog cleared, just enough to make play possible. As it seems to be the custom in matches against Westminster, Guy's was one goal down at half-time, but made a come-back in the second half, and the final score was 4–1 in our favour.

Second Round.—*v.* St. Thomas's at Guildford on February 5th.

Result: Guy's, 4; St. Thomas's, 4.

The ground was fast and the game brisk and determined from the start. The Guy's forwards went away well together and Burt soon scored after an impressive run through. A little later Parry scored from a penalty bully, and just before half-time Saunders put a fine shot high into the corner of the net from a centre. At half-time the score was 3–1 in our favour.

In the second half the Guy's side did not play so well together and at full time the score was 3–3.

In order to save a replay the game continued for an extra ten minutes each way with no score, and then for yet a further five minutes each way. In the first of these five minutes St. Thomas's scored one goal, and in the second five minutes Parr, coming up from the half-line, scored our equalising goal.

Second Round (replay).—At Raynes Park on February 19th.

Guy's, 2; St. Thomas's, 1.

The ground was much slower than the ground at Guildford, and the game was scrappy. At half-time the score was 0–1 against Guy's. But in the second half Saunders scored and later Burt scored the winning goal.

Semi-Final.—February 26th.

Result: Guy's, 3; Middlesex, 1.

Played on a fast ground at Chislehurst, the Middlesex side, though only ten men strong, gave us a hard run for our money. In the first half Wotton scored from the left wing. The half-time score stood at 1–1.

In the second half Burt scored from the centre and, finally, Thompson from the right wing.

Final.—March 11th.

Result: Guy's, 3; St. Mary's, 1.

The final of the tournament was played on the Metropolitan Police Ground at Imber Court. The Guy's side played, perhaps, its best game of the season. G. E. L. Graham, the Oxford and South of England player, St. Mary's most dangerous player, was well marked throughout and was never allowed to get away.

Halfway through the first half Saunders, backing up well, scored with a high shot into the top of the net. Later Burt scored from a melée in the goal mouth.

Play was pretty even throughout the second half, St. Mary's forwards got away together on one occasion and scored. Later Burt scored again from a centre, bringing the final score to 3–1 in our favour.

Throughout the tournament the mainstay of the team was the half-back line. Carton-Kelly, with Prideaux supporting, were almost impassable, while Richards played a particularly fine game at centre-half in the Final. Parr was frequently responsible for blocking the left side of the field, which has always been rather weaker than the right.

The last time the inter-hospital tournament was played was in 1939, when St. Mary's won the cup, beating Guy's in the final.

Team.—Goal: H. W. Trusted. Backs: B. H. Prideaux,* D. C. Dawson. Halves: L. Carton-Kelly, J. G. Richards, P. T. Parr. Forwards: G. Wotton, D. R. S. Saunders, J. R. Burt (hon. sec.), T. C. L. Parry (captain), G. Thompson.

* K. W. Bolt substituted for B. H. Prideaux in the second round and the semi-final.

Hospital Information, etc.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

February, 1944.

Surgery.—*P. D. Bryant, T. H. Eustace.
Pathology, Bacteriology and Forensic Medicine.—R. A. Leeming.
Medicine.—*P. L. Brangwin.
Midwifery.—K. Lewis.

* Have completed the examination.

Reported Prisoner of War in Japan

Mrs. Kenneth Burnham, Colonial Nursing Service (née Elizabeth Fitch), Guy's 1930–34.

Missing on Active Service

L. Merrill, Surg.-Lieut. Comdr., R.N.

Births

ROGERSON.—On Sunday, March 12th, 1944, at The Limes, Hartshill, Stoke-on-Trent, to Bettie (née Freeman), wife of Dr. C. H. Rogerson—a son.

SMITH.—On Saturday, March 11th, to Marguerite (Peggie), wife of A. Leigh Smith, Capt., R.A.M.C., India Command—the gift of a daughter.

Deaths

COCKING.—On February 29th, 1944, at Barrow Gurney Naval Hospital, Alfred Wilkinson Cocking, Surg. Cmdr., R.N., aged fifty-one years.

HERBERT.—On March 3rd, 1944, at Richmond, Arthur Stanley Herbert, O.B.E., M.D., B.S. (Lond.), of 14, Argyll Road, Kensington, W.8.

ROBINSON.—On March 1st, 1944, at 23, Carshalton Road West, Sutton, Surrey, Fredric Cecil Robinson, M.R.C.S., L.R.C.P.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

DURING our medical career sooner or later all of us must perforce meet that *dumb blonde* (a term in expressing a state of mind more than a particular hair style—or sex, for the matter of that), who, having fidgetted during what we hope has been a profitable discussion on some recent advancement in medicine, must have her little say and remark inanely, " But where does it all lead anyway ? Our grandfathers and grandmothers managed all right without all this—why shouldn't we? " Well, one represses that homicidal urge and couches a reply, perhaps giving figures on duration of life or on maternal and infant mortality rates according to the mentality of this particular blonde. As a small, very small, compensation for the War this traditional figure is threatened with extinction and happily now exists more as a figment of the cartoonist's imagination than an element of society. This is certainly progress. (Outcry from those who prefer them like that !) However, her question has left its mark and reappeared recently when it was announced that the York Clinic was to be opened as a nursing home for the psychoneurotics and the mild neuroses. This time our not-so-dumb blonde had almost qualified (some of her relations, we hear, have qualified). She wished to know, " Where exactly does all this psychological medicine lead you ? Surely a little common sense gets just as far ? and, anyway, isn't it much more important to use our limited accommodation for acute organic states than for *these old chronics* ? "

The York Clinic was designed not merely as a nursing home for mental disease, it was to further medical science in this field, a branch where we in Great Britain are far behind our American and Continental colleagues. In principle it was to provide a more ready means of liaison between other branches of medicine and psychiatry—for their mutual benefit. This was the first time the idea of a psychiatric clinic being *attached to a teaching school had been put into practice in Great Britain, though such* arrangements had been functioning for long elsewhere.

Ironically enough Guy's once did have a Lunatic House. It was built under specific orders from the will of Thomas Guy. In 1860 it was closed, possibly to the chagrin of the student body who most certainly derived as much amusement from their private Bedlam as do the present generation from contemplation of Siamese twins at a fair. We shudder to conjecture what wrath this comparison may invoke in more enlightened circles—ourselves neglected blondes—so we hastily add that the comparison was not our own, but suggested by the very instigator of the scheme himself. Since then a number of beds have been allocated for psychiatric cases in the general wards—obviously a very unsatisfactory arrangement.

More immediately the actual decision to forward at the present time the opening of the Clinic—so long delayed by the War—has been questioned. An assurance was given by the Government that it would now be safe to do so. We fervently hope they are right, yet have had definite moments of doubt. However, what is not generally appreciated is that, with the enormous increase in psychiatric illness occasioned by the War, the dearth of suitable accommodation and facilities for treatment is indeed critical. This is the vital count and, being satisfied on its validity, we wish the venture every success. We feel sure the event will be looked back upon by future Guy's men will full pride—once again their Hospital was a march ahead.

Systolic Murmurs

By MAURICE CAMPBELL, O.B.E., M.D., F.R.C.P.,

Physician and Physician-in-charge of Cardiographic Department, Guy's Hospital.

A Clinical Lecture delivered at Guy's Hospital on October 1st, 1943.

GENTLEMEN,—In the last war people were horrified at the number of recruits who were rejected on account of systolic murmurs and were supposed accordingly to have incurable heart disease. But even at that time the work which was being done on the subject was beginning to take effect; it was being stressed how much more the condition of the heart muscle mattered, and how relatively little the valvular condition; and, during the last twenty years, we hoped that a wider appreciation of this had spread among all doctors and that the wrong diagnosis of "heart disease" would be a much less common occurrence in this war than in the last.

But even now, when large numbers of young men have had routine examinations and frequent re-examinations from time to time, we are still disturbed at the large number of cases in which there is doubt about the diagnosis. A man may even be made neurotic during the period of weeks or months when he is being questioned about his heart and put on light work and perhaps brought before boards and examined by specialists.

It is therefore extremely important to try to get clearer ideas on the diagnosis of valvular disease. Diastolic murmurs are easy, if they are heard; the problems of interpretation only arise with systolic murmurs. That is why I have chosen this subject to-day, and I want to give you some rather simple dogmatic teaching on how you should examine cases with systolic murmurs and what conclusions you should draw.

If you turn to the old *Guy's Hospital Reports* of thirty or forty years ago and look through the index of diseases you will find that mitral regurgitation is one of the commonest diseases indexed. If you turn to an excellent book like Cabot's *Facts on the Heart*, published about 1925 (the author was a general physician, not a cardiologist) you will find that he has one chapter in a book of many hundreds of pages devoted to that rare condition, mitral regurgitation. Recently William Evans has had a short article in the *British Medical Journal*, which, I think, has led to still greater confusion amongst students because he hints that systolic murmurs may justify a diagnosis of mitral stenosis. Now, your examiners will be troubled if you quote such a remark, for they will not know whether you are ignorant of the series of events in the cardiac cycle and have mixed up diastolic and systolic murmurs, or, on the contrary, very up to date in quoting such a recent view. I think the statement rather unwise because of these complications, but it is another illustration of how the pendulum has swung.

In considering the question to-day I want first of all to talk about systolic murmurs associated with diastolic murmurs and I shall be able to dismiss this shortly; then systolic murmurs associated with a thrill, on which there is a little more to say; then systolic murmur associated with cardiac enlargement. All these three subjects are simple and definite, and I do not think there is any difference of opinion among any of your teachers on the subject. Finally, a more difficult question, on which there are more differences of opinion and more difficulties in interpretation, is the systolic murmur that is found without these other cardiac signs and without cardiac enlargement.

SYSTOLIC MURMURS ASSOCIATED WITH DIASTOLIC MURMURS.

In this first group one can say that a diastolic murmur is nearly always definitive in its significance. When difficulty does occur it is rather in hearing the diastolic murmur than in knowing what it means when you do hear it. I should like you to remember that you have never examined a heart properly until you have listened, saying to yourself at the time: "Can I hear a diastolic murmur?" If you accustom your ears to the systolic murmur you may easily miss the diastolic, and therefore you have to listen specifically for it. If you hear the systolic murmur at the base of the heart associated with a diastolic murmur the question is whether it means aortic stenosis. It has been said that you should never diagnose aortic stenosis unless there is also an aortic diastolic murmur. If it is associated with a thrill it is easy. If it is just a rough harsh murmur heard in the aortic area you should look carefully for the associated signs, including the small pulse pressure, the rising anacrotic pulse, and make your decision after taking all those things into account.

Another type of systolic murmur at the base associated with a diastolic is that due to patent ductus arteriosus. Those of you who have not heard the murmur should still be able to recognise it the first time you do so because it is so different from any other murmur you have heard. It has a loud rushing sound the whole way through systole and the whole way through diastole.

At the apex a systolic murmur associated with a diastolic murmur merely adds to your diagnosis of mitral stenosis by an indication that there is regurgitation as well. In fact, whether you hear a systolic murmur or not, if you think of what the mitral valve is like in the case of mitral stenosis it is difficult to imagine that there is not some degree of regurgitation in all cases of stenosis and that the two things are not closely associated. But probably in some of them it is not very large and therefore you do not get your well-marked signs of regurgitation, whereas in others the valve is so arranged that regurgitation occurs to a considerable extent and you get a systolic murmur with a diastolic one.

In all this group the diagnosis depends mainly on the diastolic murmur, and the systolic murmur helps by showing that you have also aortic stenosis or some congenital abnormality or mitral regurgitation as well as stenosis.

SYSTOLIC MURMURS ASSOCIATED WITH A THRILL.

This is the second group I want to speak of and some of you may say that you have not come across a great many cases with a thrill; it is, in fact, very often a thing which has to be felt for. Some cases are so striking that they are difficult to miss, but in many even a well-marked thrill can be missed. I cannot tell you whether you should use light pressure or firm pressure, because different thrills are felt more easily with different degrees of pressure; therefore you should always put your hand on very lightly and also put it on firmly. The right position is to have the patient sitting up and leaning forward so that the heart and vessels are in the closest contact with the chest wall, this providing the best opportunity of getting transmitted thrills. A basal thrill has a very real significance in determining what a systolic murmur means. If it is best felt in the aortic area you have a confirmation of aortic stenosis, and that is the only thing that justifies a diagnosis of aortic stenosis in the absence of aortic regurgitation. If it is best felt on the left side of the sternum, it is almost diagnostic of pulmonary stenosis and you look for confirmatory evidence of this form of congenital heart disease. You will observe the shape of the heart under X-rays and, if it is a marked case, you will notice the picture of polycythæmia and clubbing of the fingers, though this often means there is a defect of the interventricular septum as well.

It is uncommon to get a diastolic thrill at the base of the heart, and therefore any thrill felt at the base is probably systolic. But you must watch your timing carefully because exceptionally in gross aortic regurgitation you may get a diastolic thrill at the base, and in patent ductus arteriosus you may get systolic and diastolic thrills both long continued at the base of the heart, over towards the left.

There is one congenital condition by no means rare which gives you very similar signs to aortic stenosis, namely, coarctation of the aorta. There, instead of the stenosis being at the valves, it is a few inches further round the arch of the aorta, so that you may find your signs and your thrill well in the pulmonary area. But there are many associated signs with it—a high blood pressure in the arms, or sometimes in the left arm only, and a relatively low blood pressure in the legs, and the collateral circulation shown through the back, particularly around the scapula, and, again, in the X-ray picture the appearance of notching of the ribs by the intercostal arteries. This should not, therefore, lead to any difficulty.

Systolic thrills associated with systolic murmurs are less common at the apex than at the base. They prove in every case that the systolic murmur is significant, and so we can leave their interpretation until we come to discuss other systolic murmurs of the apex. The presence of the thrill lets us know that the systolic murmur is really significant.

The deduction to be drawn from those two groups is that *whenever you hear a systolic murmur the first things to do are to listen carefully for a diastolic murmur and to feel carefully for a thrill.* In many cases you will find one or other or both of these, and then your diagnosis is simple and straightforward.

SYSTOLIC MURMURS WITH CARDIAC ENLARGEMENT WITHOUT THESE OTHER SIGNS.

In many cases, of course, there will be cardiac enlargement associated with the diastolic murmur as well, or associated with a thrill; this is an addition to your picture of the case. But this third group is concerned with the systolic murmurs associated with cardiac enlargement, but without diastolic murmurs, and generally without a thrill, though I have left the apicical systolic murmur and thrill to be discussed with this group.

This group includes one of the commonest types of systolic murmur. I cannot give you a certain explanation of how or why it is produced. Many patients with a large heart, whether this is secondary to high blood pressure or to other arteriosclerotic changes, have a loud systolic murmur. Such cases are very common and they led in the past to mitral regurgitation being such a common diagnosis. The objection to recognising this as a sign of mitral regurgitation is that the other expected signs are not found associated with it. Neither on X-ray examination nor in the post-mortem room is the left auricle found to be enlarged and hypertrophied, which is the first sign to be expected with mitral regurgitation and a thing that is found in cases where mitral regurgitation is associated with mitral stenosis.

It used to be taught that regurgitation was due to stretching the mitral valve in these conditions, and this may be the truth; others think it is due to the hypertrophied heart and that the contraction of this large mass of muscle leads to some change of the normal heart sounds into a systolic murmur. When there are several theoretical explanations I do not think the theories are important for practical clinical work, because obviously there is no conclusive evidence. Therefore I think we can leave the explanation of what these systolic murmurs are due to and say that they have no significance as regards the diagnosis of any particular cardiac condition. You cannot divide up the treatment or prognosis of your patients with cardiac hypertrophy according to whether they have systolic murmurs or not. You cannot say from experience in the post-mortem room that those patients who show systolic murmurs will have one type of heart and those who do not will have another. Therefore, although the presence of the systolic murmur is organic and is a reason for looking for cardiac enlargement and for taking the blood pressure, it does not add significantly to your diagnosis.

The further diagnosis of such a case depends on the associated symptoms, whether the patient has signs of failure, whether he is dyspnœic, and what is the degree of cardiac enlargement. Although the systolic murmur may sometimes be the first thing that draws attention to the condition, in most cases it is no more than an additional sign after you have once made the diagnosis.

This means that systolic murmurs associated with cardiac enlargement will in most cases be in elderly patients. I am afraid " elderly " in the cardiac sense means anything from forty-five upwards, for that is the age at which these arteriosclerotic changes may start. This is the commonest systolic murmur associated with cardiac enlargement. Thyrotoxicosis produces similar changes and this may, of course, occur in younger patients.

True mitral regurgitation in a rheumatic patient is uncommon without mitral stenosis, but there will be a large number of cases where the systolic murmur and the enlarged heart are found with an old rheumatic history. You will be inclined to believe that those cases are mitral regurgitation of the same type as is found associated with mitral stenosis. Often you can make certain of this and the systolic murmurs have been the sole sign simply because you have not looked carefully enough for the presystolic or diastolic murmur of mitral stenosis. If you exercise the patient and examine him on the left side after exercise you will often find that a diastolic or presystolic murmur was really present as well as the systolic murmur.

This means, as the earlier findings of a systolic murmur did, that you must search carefully for a thrill and a diastolic murmur, and also for any other evidence of rheumatic heart disease or congenital heart disease.

The last thing I should like to say about this group is that if you have a systolic murmur and cardiac enlargement and can find nothing else you must be absolutely certain that it is real cardiac enlargement. Unless you are certain, unless the cardiac enlargement is so gross that there is no mistaking it, you must not make this diagnosis. You must always bear in mind how serious it is to make a diagnosis of heart disease in someone otherwise fit. These are the cases in which you should confirm your view of cardiac enlargement by insisting on an X-ray examination, and you may then find

that in some of the cases with a systolic murmur there is no real association with cardiac enlargement, but that the heart has been moved over a little to the left either from scoliosis or from some lung condition, and so the case does not fall into this group.

In these three groups, therefore, complete examination will generally answer your questions and, while a systolic murmur in itself will not be of decisive importance, it will lead you to find other things on which the final diagnosis can be based.

Thus we come to the last group about which I want to talk particularly to-day.

SYSTOLIC MURMURS WITHOUT THRILLS OR DIASTOLIC MURMURS OR CARDIAC ENLARGEMENT.

I am going to make a dogmatic statement to which I shall have to make some exceptions later, that in no case should you be influenced by this one sign alone, in deciding what you allow the patient to do. If the only finding is a systolic murmur without cardiac enlargement then let the patient lead the same life as before, do not insist on any restrictions, and in most cases do not mention to him that he has systolic murmur at all. You cannot rely on him and his friends to differentiate between your careful explanation that it is a murmur which does not much matter although other heart murmurs do, and, in most of such cases, it is better not to say anything about it at all. The difficulty is that when the patient comes to be examined by somebody else in the near future. If this fresh examiner tells him that he has a murmur he will think that you have been careless or ignorant. You may feel, therefore, that the wiser course is to explain to him that there is a murmur but that it does not matter, though if he is your patient and is not likely to see someone else the wisest course will be to keep the information to yourself. But you should never fail to make a note of it even though the murmur seems to you of no importance. I think we should go further and say that every time we have the opportunity of examining a child, whether in some infectious condition or in routine school examination, we should make careful notes of just what systolic murmur we hear. In some of the cases such a record will never be wanted again, but in a number—it may be in the following year or five years later—you may see the patient again in some doubtful illness, perhaps diphtheria, perhaps rheumatism, and the systolic murmur will be heard. You will then wonder whether it means cardiac involvement, and if you are able to look up your notes and to find a perfect description of what was elicited at the earlier examination and which fits in with what you now find, you will have gone a long way towards deciding whether it is of importance or not. Thus a record of the sort of systolic murmur which is present will be of the greatest value.

I have put on the blackboard a short list of questions which you must ask yourselves about these systolic murmurs :—

(1) What is the site ?
(2) Is it conducted ?
(3) Is it the same in the lying and sitting positions ?
(4) Is it influenced by different phases of respiration ?
(5) Is there a history of rheumatic fever ?

The first four are things which you can find out for yourselves on examination of the patient, and you may think that my fifth question is an unfair ome because it depends on history and not on examination, but the subject is so difficult that you cannot afford to do without any relevant information.

First, as regards *the site*. Systolic murmurs alone at the base of the heart practically never means anything decisive. Some years ago I saw a patient who had carried through all his military duties in the last war until his medical examination before being sent to France, when someone heard a systolic murmur at the base of his heart and told him he had aortic stenosis. He never went to France, and ten years later when I saw him he was still a neurotic patient, anxious about his heart and unable to do much work. I hope that later on you will be able to look back and say that you are not responsible for any case like that. It is very much better to be a week or two late in making a diagnosis of a systolic murmur that really matters than to make a premature diagnosis which produces such devastating effects. A wrong diagnosis of heart disease is always difficult to upset, because, however eminent the consultant to whom the case is next referred, the patient will always have an uneasy feeling at the back of his mind that the first doctor was a very clever one, who heard something that no one else can hear. Therefore it is of extreme importance that you should know whether what you hear matters, and you should be very careful what you say about it.

I think that you will rarely go wrong if you stick to the rule that a systolic murmur at the base of the heart, with nothing else, has no significance. If the systolic murmur is at the apex you have a most difficult problem, and I will come back to that in a few minutes.

There is one other site that is important, the low sternal one. A systolic murmur heard there, which fulfils certain other criteria which I shall come to in discussing the other questions, may be the only indication of the commonest of all congenital defects, namely, a defect of the intraventricular septum. Thus there is one common condition which often has to be diagnosed on a systolic murmur only. You may get a confirmation by some right-sided preponderance in the cardiogram or by a rather globular-shaped heart on radioscopy, but often the diagnosis has to be made on the systolic murmur alone.

Is the murmur conducted ? If it is conducted for any great distance it is nearly always due to valvular disease and is a significant murmur to which you must pay attention. You know the classical cases of the systolic murmur at the apex that you can hear conducted right round to the axilla or round to the back. Those cases should lead to no doubt. Most murmurs can be conducted for about one inch, but as a rough guide I would say that the conduction of the systolic murmur for more than two inches from the site where you hear it best, unless it is fading away and becoming very faint, is presumptive evidence that it has some significance.

Is it the same in the lying and sitting positions ? If a murmur goes when the patient is lying or when he is standing you ought to appreciate at once from your knowledge of physiology that it is difficult for it to be produced by valvular disease, and easy to see how it may be produced by something outside the heart. If the murmur is much changed when the patient is lying and when he is sitting, almost certainly it is not significant.

Is it influenced by different phases of respiration ? The effect of respiration is nearly as important but a little more difficult. If a systolic murmur is heard in one phase of respiration and not in another in ordinary quiet respiration, it is probably of no significance. If you get the patient to breathe deeply and can make the murmur change as a result, it is probably again of no significance, but one has to qualify that a little. The effect of respiration is sometimes decisive, but at other times it still leaves you in doubt as to whether you have got to make any diagnosis from that murmur alone.

This is where the last question comes in : *Is there a history of rheumatic fever ?* The systolic murmur you hear in the young adult is really only due to one of two things : it is due to some form of congenital heart disease (and at different stages of this lecture I have mentioned most of the commoner types of congenital heart disease that might be concerned) or it is due to rheumatic infection of the mitral valve.

If you have a history of rheumatic fever you are going to be more careful before you say that a murmur has no significance, and I am not ready to say that all murmurs which are influenced by respiration in a patient with a rheumatic history can be neglected. If they are very greatly influenced by respiration so that they disappear entirely in one respiratory phase, then you can neglect them, but if there is only a little change in the ease with which you hear the murmur this is suspicious, and if there is a rheumatic history you must pay attention to it.

Therefore, if the murmur is not conducted, if it changes when the patient moves from the lying to the sitting position, a change with respiratory phase will be decisive and you need pay no attention to the murmur whatever. It is not due to heart disease and should not in any way influence the life of the patient. You do not in fact find many cases where these three indications are at variance. You will generally find, for example, that a conducted murmur is present both in the lying and sitting positions and is constant at all phases of respiration. You will often find that a murmur which is not conducted varies on lying and sitting and varies with respiration. But if two of these things point one way and the other points a different way, then I think you must be guided by the majority. If two of the ways suggest that it is significant then you must regard it as significant, and if two favour its insignificance you may neglect it and let the patient lead a normal life.

But I have also brought in that final question : if there is some doubt about one of these answers and there is a history of rheumatic fever then the case justifies an early full examination with X-rays and electrocardiogram to decide this fundamental question of whether the patient has slight rheumatic heart disease or not.

I should like to say one final thing on these murmurs before trying to give you a little explanation of what the murmurs which are not significant may be. If you are in doubt as to whether a patient has congenital heart disease or not, have some confidence in yourself and realise that probably he has not gross disease and that you will not do much harm and may do a great deal of good by telling a patient who is anxious about a small septal defect that his heart is all right. It is not a thing for which you can adopt any treatment, it is not a thing which leads to any trouble in the future, and therefore, if there is doubt, it is much better to let the patient lead a normal life.

That is another reason why I put in the last question about rheumatic fever. If you are in doubt about any systolic murmur you should allow the patient to neglect it and lead a normal life unless there is a history of rheumatic fever, and that means a fairly recent history if it is to influence your practical treatment of the patient. If somebody is thirty years of age and has had no symptoms of any sort but has some doubtful systolic murmur, the question of whether he has had rheumatic fever may have a bearing on whether he has some slight degree of mitral endocarditis, but it has no real bearing on his capacity to do things and it can still be neglected. On the other hand, if you are dealing with a child of twelve, where a recurrence of rheumatism is a possibility, a recent rheumatic history will justify you in being extremely cautious about any decision on a systolic murmur and it may be wise to rest such a patient and keep him under observation until you have excluded any active rheumatic infection.

SYSTOLIC MURMURS OF NO CARDIAC SIGNIFICANCE.

I should like to spend the last few minutes of this lecture in discussing those systolic murmurs that are not significant of heart disease. We are on much less certain ground than in discussing a thing like a presystolic murmur. The commonest of all, I think, is the cardio-respiratory murmur. If you listen to half-a-dozen of your friends you will find that at least one of them—probably two or three—has a cardio-respiratory murmur, that is, a systolic murmur that is heard in different phases of respiration and perhaps heard only when he is standing or when he is lying. You should all take the opportunity of hearing some cardio-respiratory murmurs and of realising from your own practical experience that these do occur in normal people who have nothing wrong.

An explanation that has been given is that a small part of the left lung comes forward over the upper part of the heart and that the contraction of the heart muscle behind drives a little air out of the lung and causes the systolic murmur at that particular phase of respiration when there is the right amount of air in that part of the lung. This is probably right, but it is far more important to realise that the murmur is a common finding in normal people than to know just how it occurs.

A second systolic murmur which is extremely common and of no significance is produced by anæmia. Most people with anæmia have a systolic murmur at the base of the heart, and some have a systolic murmur at the apex as well. If you have a patient with anæmia it is the anæmia that needs treatment and not the systolic murmur. In many cases of gross anæmia, with 30 or 40 per cent hæmoglobin, as the anæmia improves, the disappearance of the systolic murmur can be observed.

Another condition is fever. Many children with fever have a systolic murmur. Perhaps it is due to nothing more than the tachycardia associated with the fever. If you listen to them in health when lying down you might notice it with a similar degree of tachycardia. You must not think that every time you hear a systolic murmur in somebody in bed with fever that it is any evidence that the heart is involved. It is a common finding, and unless something else is present there is no reason for comment and still less for influencing your treatment of the patient.

Another not uncommon and rather difficult murmur occurs in diseases of the pleura such as tuberculosis. The murmur is produced by something outside the heart, in the pleura or the pericardium. I have had patients sent to me for an interpretation of a systolic murmur when they were in the early stages of tuberculosis. I have seen other cases where the systolic murmur is the relic of a pneumonia and does not represent heart disease. It may be due to some slight pleuro-pericardial adhesion. The murmurs in these cases are likely to be what are called late systolic murmurs, but they may sometimes be quite loud, and occasionally even harsh, and rather constant. Therefore they are an important group. Some of the late systolic murmurs may still leave you in doubt as to whether they are significant or not. A most interesting case of that type (interesting because I feel I can give the complete explanation) was a patient who had had pneumonia and was sent up as suspected bacterial endocarditis because he was

found afterwards to have a systolic murmur. He had had pneumonia of the left side, with pleurisy, and one had very good grounds for saying that his murmur was one of the exocardial murmurs. On X-raying him one could see an irregularity of the diaphragmatic movements where there was an adhesion following from his pleurisy. In that particular case we happened to know that he had not had a murmur previous to his attack of pneumonia.

That gives you three or four common conditions that are responsible for many systolic murmurs. I hope that it will be of assistance to you when you are confronted outside the hospital with cases in which a systolic murmur is heard.

To sum up, the finding of a systolic murmur is a good reason for a very careful search for diastolic murmurs, for thrills, or for cardiac enlargement. If you find these you know you have heart disease and you have well-established methods of settling what the diagnosis is. But if you find none of these things accompanying the systolic murmur, then you may turn to the detailed examination of the type of murmur, and by its constancy in different positions of the patient and in different phases of respiration and by finding whether it is conducted or not, you may come to some conclusion as to whether it does represent heart disease, most commonly rheumatic disease, sometimes congenital disease, and sometimes in a middle-aged person some early atheromatous changes. If it does not represent these things it has so significance whatever as regards the heart and the patient should lead a normal life in every way and is probably much better for not knowing that he has a murmur.

Night-Fighter

HUNTER, Defender, I fly through the night blue sky to the coastline.
Dark is the earth, cities shrouded, no friendly lights twinkle in welcome.
Patterned fields spread below me, pale in the glimmering moonlight.
"Oh, fickle moon! In your turn my enchantress, my friend, my betrayer."
Honest stars guide my course—Gemini, Wain and Orion,
Hunter himself and my brother. "Great Sirius, be thou my watchdog!"
Free of the air we range, the Master thy course has appointed;
Mine you aid me to follow, my ultimate goal still uncharted.
Lovely the night is and mighty the roar of my thousand-horse engines.
Hush! the radio warns: "Bandits approaching to starboard."
Alter course; we're converging; he's shearing off; overtake him!
Tally ho! noise; lights; quick fire; the air-gunner mad with excitement
Eager for more, but the quarry spins down in a glow to destruction.

* * * * *

Dawn pales the sky; beauty paints tender hues from horizon to zenith;
Duck flight; larks soar; birds cheep; sleepy beasts stir in the meadows.
Old carp blow in the lake; quiet trout make rings on the water
Rising to flies; only man, sluggard and weary, still slumbers.

* * * * *

Breakfast! The pilot turns home, fried bacon and eggs in his nostrils;
Thinks of a bath, the long sleep, when interrogation is over.
Smoothly I fly, not unscathed, air gunner and pilot conversing.
Jubilant, happy, relaxed, but vigilant ever and ready.
Home! Permission to land? Safe down! "Good work!" Now the ground crew,
Craftsmen eagerly searching, with dominant fingers restore me.
My crew rejoin the mess, that band of welcoming brothers
Who, for England's sake, banish fear, enduring, high hearted,
Fighting the Gorgon to bring to a tortured world liberation.
Peace to the fettered nations. Husband and wife by the fireside,
Boys and girls at play and laughing fat little babies.
Young men growing in grace free—free at last from the terror—
Therefore I fly through the night.

E. P. M.

Correspondence

HEALTH SERVICE.

To the Editor of the GAZETTE.

SIR,—Surely before such a radical step as putting an inhuman bureaucracy in charge of the nation's health is taken, the people of the country must be able to compare existing and proposed arrangements. This it cannot do from any paper schemes, however well advised by experts, medical or lay, as was evidenced by the varied and opposing opinions expressed in the Commons last week.

An experienced practitioner made some very sensible suggestions in a letter to the *New Statesman* of March 18th. Fundamentally these rested on the fact that the Government should establish a Health Service which competes *openly* with existing schemes. By this method the Health Service would be built up gradually, a comparison with the old ways would be possible, and there would be a constant spur to the Government to provide the best treatment for the patients and the best conditions for the doctor.

In addition, such an arrangement would have the advantages of a gradual change and the chance of making experiments locally and generally—*e.g.*, in the type of health centre to be adopted, the effects of a fixed salary upon the quality of work done and method of administration.

Yours, etc.,

JOHN D. WALLACE.

Another Letter from "Sinbad"

H.M.S. *Verucca*
January 1944
North Atlantic.

MY DEAR BILL—Some people still think that naval medicine is mainly venereal; in my experience this is not so. but V.D. is bound to be a problem in any community of young men because while its early treatment and diagnosis is important it is even more necessary to prevent it. Most of your patients will be young and ignorant. A high proportion of sea-going men are between the ages of eighteen and twenty-five and it is at these that your main effort should be directed since they are at once more likely to go astray and to respond to advice.

It is a crime to conceal V.D. in the Service but although getting it involves no penalties apart from stoppage of pay a man may not be advanced (promoted) while under treatment.

The problem has to be attacked in two ways—prophylaxis and education. Prophylaxis is intended to ensure that men have condoms, protective ointments and instructions about washing themselves, etc. before going ashore. Packets of calomel and silver picrate can be obtained from Canadian bases but these are not issued in England. Most of the large towns have centres with irrigation sets; this is good in intention but as the victims are often drunk at the time they do not avail themselves of these measures a long-term educational policy is necessary. In my opinion short intensive campaigns combined with carefully-worded talks to individuals who come up believing they have been infected is the method of choice. The intensive campaigns should combine every possible method of approach. The Ministry of Health provide excellent poster sets which give a vivid warning of the danger but emphasising, as all such propaganda should, that it can be cured but is much better avoided, rather than simply piling horror on horror. Marcel Brieux's play "Damaged Goods" is a good investment. I have half-a-dozen copies for distribution round the mess decks which are always short of reading matter. Try to get the Leading Hands of messes ("leading hand" is the naval rating roughly equivalent to corporal) to co-operate in getting their messmates to send in any questions which may puzzle them and answer these over the broadcast system. General measures which concern you but are outside your personal scope should be undertaken in co-operation with the other M.Os. in your group to encourage the base authorities to provide improved recreation facilities; buy blocks of cheap theatre and cinema seats; have canteens close to the docks; and to arrange

special transport to get the sailor back to his ship where this is lacking Jack is left on the streets ready to be picked up by the first prostitute or good-time girl who comes along; drunk, lonely, young and fuddled it requires little guile to lure him into a relationship which he usually regrets next morning.

Scabies, impetigo and epidermophytosis are the skin diseases which I have seen most frequently. I treat scabies in the officers' bath, having previously reassured them that they will not become infected. The benzoyl benzoate is best carried concentrated and made up into a water emulsion on board with 2 per cent. Lanette wax. The wax is melted in a bowl held over a large bowl of very hot water and the benzoyl benzoate added slowly; hot water is then run into this and a satisfactory emulsion forms. Strict supervision is needed for the first two or three patients; the skin must be painted thoroughly with a 2½-inch paint brush. You should do at least one patient yourself to show the S.B.A. Patients should never be allowed to apply the emulsion to themselves since they will usually skimp it, especially if it stings their skin. There is a remarkable range in individual sensitivity to benzoyl benzoate; one of my patients fainted with the pain, while others said they hardly felt any irritation. Kenneth Mellanby has shown that sterilisation of clothing is unnecessary. I usually give two applications of emulsion with a week's interval in between.

Epidemophytosis, accompanied by an extensive secondary sensitisation eruption, has given me some trouble; it is usually very much worse in warm climates, and men who suffer from it when in home waters should not go abroad. I have had several cases of taenia circinata which have been very stubborn; nor is prophylaxis easy.

Throats are always going wrong and, in case you have forgotten it, I recommend Layton's mouthwash, which consists of two mouthfuls of strong soda bicarbonate solution followed by one mouthful of 1 in 5 vinegar. This is not gargled, but circulated vigorously round the mouth and the whole process takes at least five minutes; it is effective and the ingredients are easily stocked. Vinegar is also handy for acidifying urine when testing for phosphates. Teach your S.B.A. early on to make ear swabs, since a good supply of these saves time when you are clearing out an ear. Although the electric otoscope is convenient, direct vision with a head mirror is usually possible; sunlight coming through a scuttle makes an excellent source.

Bleeding gums are very common and occasional cases of Vincent's infection occur, perhaps due to the fact that fresh vegetables can only be carried from three to four days and that the method of cooking and storage are both old-fashioned and result in reduced vitamin content. At the end of each trip your S.B.A. should canvass the messes for men wanting dental appointments. You can then visit the "toothie" yourself and arrange grand purge; this will avoid men complaining of toothache on the first day out, and you may well discover a fellow Guy's man at the base.

As medical officer you should observe the men's living conditions, latrines, washing places, cooking facilities, etc. But, before you start writing a report upon the bad conditions—and bad they certainly are—so crowded that lack of hammock space makes it necessary for them to sleep on tables, lockers, benches and sometimes even the deck, you must decide upon a positive policy. Mere exhortations will be received coldly both by the Admiralty and your fellow officers because everyone knows that there are more men on board than there ought to be, but new weapons and the need for ships has made it necessary to sacrifice living conditions to fighting efficiency. The men understand this and it is in this situation that the way the ship is run makes the difference between happiness and dejection. In a happy ship the company, in spite of their bad material conditions, will remain in good spirits, while the most luxurious accommodation will not ensure that all will be well. You can help by letting the first lieutenant know of any little matters that reach your ears.

As soon as you have settled down note all faults and start getting them repaired during the periods of boiler-cleaning when you are in harbour. When the ship is refitted, with luck and cunning you will be able to get your sick bay reconstructed. Your captain will usually be sympathetic, but the base staff may require any amount of wheedling. It is a mystery to me that there seem to be no standard fittings and equipment for sick bays in old ships which did not have one previously; it is a matter of chance whether you get to the ship at a time when you can have alterations done. It is cold comfort to be urged to do your best with defective equipment which hampers your attempt to work under conditions already difficult. There appears to be a belief that, provided a cabin is set aside and a doctor sent to the ship a few days before she sails, honour is satisfied. This, of course, only applies to the older ships; modern ones of American construction are splendidly equipped.

When you are either out in the stream or anxious to get a sick man over the side at sea you will have to lower him in a Neil-Robertson stretcher, an experience which, in choppy weather, is exciting and terrifying. Once the patient is lashed up comfortably and you have made sure all the straps are tight the rest of the job should be left to seamen, for, although in theory this should be done by the sick-berth staff under your supervision, it is not remotely likely that you and he will have the knowledge of knots and hitches, dexterity and cunning of hand which can only be acquired from years of boatwork and is never learnt out of books. Watch the work with wonder and admiration and without offering any advice. The first lieutenant will take charge and your man will probably be lowered from a torpedo davit. Sometimes the Neil-Robertson is unsuitable and a chair may be used. I had the greatest difficulty in persuading a very senior officer that my captain, who had broken three ribs could not be placed in the stretcher because the pain it would cause him would equal that of being racked. The great man agreed at length that we must think of some other method, which we did.

I have had much kindness from the R.A.M.C. and R.A.F.M.S. and, at bases where there were no naval hospitals, they treated my patients and invited me to their messes. When possible get them down to the ship ; it is a pleasant break from routine work and, in a newly established base, you may be able to offer that most valued of gifts, a bath. A few months ago I met a fellow Guy's man who intrepidly had set up his dental surgery under a tent in the middle of a ploughed field in the Azores, surrounded by trampled sweet corn with a fruitful fig-tree in front of it.

I have found the ethyl chloride spray method for sprains usually successful and often magical. A colleague in a sister ship discovered that by blowing upon the area while spraying, freezing took place more quickly and ethyl chloride was saved. When the skin is frozen the joint can be put through a full range of movements ; the method is fully described in the *Bulletin of War Medicine*. Curious skin reactions occur for as long as five to six days after the freezing and spraying should stop as soon as the skin blanches. It is, of course, essential to exclude bony damage before using the spray. Sprains are common in the Service and may prevent a man from doing his work longer than a similar accident on shore, because you cannot allow a man on the upper deck who cannot trust all his limbs.

I shall never regret nor forget my year at sea in this old, infirm, decrepit yet marvellously tough and seaworthy old ship. There are no warships of their age to touch these Vs and Ws.

In retrospect I can imagine jobs which would give more clinical experience, some even more independent, others more exciting, but for combining elements of these three with friendship, informality and variety there can be few places equal to the *Verucca*.

Yours as ever,

"SINBAD."

P.S.—N. R. James's "Regional Analgesia in Intra-Abdominal Surgery" seems to answer many of the queries in my previous letter. Price 6*s*., from Messrs. Churchill.

Sport

Rugby

GUY'S *v.* R.N.Z.A.F.

(*Played at H.O.P. on February 26th.*)

Result: R.N.Z.A.F, 3 penalty goals (9 points); Guy's, 1 goal and 1 try (8 points).

Once again our encounter with R.N.Z.A.F. was a fast, furious and clean struggle. As the score suggests it was an even game. With no wind or sun Lee, winning the toss, chose to play towards the pavilion. For the first twenty minutes the play was mostly in midfield with forwards of both sides scrumming well in the loose and the outsides seeing little of the ball. The game then opened out, Bailey making his first appearance against a heavier and more experienced opponent, and with fast breaking wing forwards he showed promise. The Blacks' outsides, who were fast and handled the ball excellently, pressed dangerously with quick passing movements. An infringement under the posts gave R.N.Z.A.F. a penalty goal. A determined rush by Graham and Jones nearly led to a try, but they lost control of the ball near the line. This encouraged Guy's considerably and, after pressing hard, Vidot scored a characteristic try from a line out, Jones converting with a remarkably fine kick. The game then deteriorated until half-time into a forward slogging match with many dropped and fumbled passes on both sides.

The second half was more vigorous. Guy's were packing better in the tight and Lee's hooking was first-class. The ball went out more smoothly on both sides and hard running and tackling made pretty football—Guy's relying on short kicks ahead, "Blacks" on quick passing. Macdonald kicked a good goal from a penalty. Smooth passing to Boyd, a strong run, back to Jones and inside to Harvey, led to another try, which was unconverted. It looked as though Guy's were back to their form after a series of ignominious defeats. Powerful defence all round prevented any further score. However, an infringement by Guy's under the posts gave R.N.Z.A.F. a lead, to which Guy's had no time to reply.

Tunbridge Wells Rugger

The return of the Medical and Dental Schools to London from Tunbridge Wells has meant the cessation of rugger at Tonbridge Club, except, perhaps, as visitors in future seasons.

Guy's Hospital students have been very fortunate in being able to carry on their Rugger, in spite of all the difficulties caused by evacuation, for five very enjoyable seasons.

In 1939, when Guy's moved to Tunbridge Wells, nobody had any idea when students would be able to carry on their Rugger, until one day a few students were having coffee with Mr. French, the organiser of the Tonbridge Club teams. When he was told that Guy's students were wondering where they could play some Rugger, it was he who looked into the matter of letting students use Tonbridge Club and their Rugger pitches.

From that day a great friendship has developed between Guy's and Tonbridge; never a grouse from anyone.

Since Guy's has been in Tunbridge Wells Messrs. P. Harvey, P. S. Campion, R. A. Dean and J. W. Kilby have done admirable work in keeping the Rugger going, and managing to get up two regular teams throughout each season. Our grateful thanks go to Tonbridge Club for allowing us to use their club, how and as often as we liked. In recognition of this a supper was held in the club-house on Saturday, March 11th, after our final match with the club for this season.

Among those present were:—C. Greenhall (Chairman, T.R.F.C.), L. A. Le May (Hon. Sec., T.R.F.C.), J. N. Lawrence (captain, T.R.F.C.), Dr. ("Tubby") Evans, A. Batty-Shaw (Hon. Sec., G.H.R.F.C.), A. C. Macrae-Gibson, E. W. Graham, R. C. Holloway.

D. F. P.

Hospital Information, etc.

Pass List

EXAMINING BOARD IN ENGLAND.
PRE-MEDICAL EXAMINATION.
March, 1944.

Passed.

Chemistry.

J. W. McLean — C. B. Palmer

Physics

W. I. Abell — C. R. Wilkinson
R. E. Breen Turner

Biology.

W. I. Abell — J. W. McLean
A. A. Bailey — C. B. Palmer
A. A. Krantz — C. R. Wilkinson

GUY'S HOSPITAL MEDICAL SCHOOL.
March, 1944.

The following awards have been made:—

The Sands Cox Scholarship in Physiology.
E. L. W. Leiser, I. Yentis .. } Bracketed equal.

The Michael Harris Prize in Anatomy.
H. Goldschmidt .. Prize.
R. H. Browning, E. L. W. Leiser } Certificates.

Prize in Embryology.
D. G. A. Westbury .. Prize.

Junior Proficiency Prizes.
H. Goldschmidt .. First Prize.
R. H. Browning, M. P. Coplans, E. L. W. Leiser } Second and Third Prizes shared equally.

Awards

M.B.E. (Military Division).

Major K. R. D. Porter, R.A.M.C.

Papers by Guy's Men

Reed, C. P. B. A Press for Acrylic Resin Dentures. *Brit. Dent. J.*, 1944, **76**, 125.

Eustace, R. J. Acute Ulcerative Gingivitis. The Prevention of Relapse. *Brit. Dent. J.*, 1944, **76**, 83.

Paterson, D. M. The Dentist and the Law. *Brit. Dent. J.*, 1944, **76**, 87.

Rushton, Martin A. Growth at the Mandibular Condyle in Relation to Some Deformities. *Brit. Dent. J.*, 1944, **76**, 57.

Goodhart, G. W. Hæmolytic Hypochromic Megalocytic Anæmia Associated with Postmalarial Splenomegaly. *Proc. Roy. Soc. Med.*, 1944, **37**, 85 (Clin. Sect.).

Barber, H. W. Circumscribed Scleroderma of the Buccal Mucous Membrane. *Proc. Roy. Soc. Med.*, 1944, **37**, 73 (Sect. Dermat.).

Dowling, G. B. Pigmented Lesion of Neck. *Proc. Roy. Soc. Med.*, 1944, **37**, 75. (Sect. Dermat.).

Witts, L. J., and Others. A Clinical Evaluation of Some Tests of Liver Function. *Brit. Med. J.*, 1944, i, 211.

Hurst, Sir Arthur. Nervous Disorders of Swallowing. *Clin. J.*, 1944, **73**, 1.

Slesinger, E. G. Acute Appendicitis. *Clin. J.*, 1944, **73**, 7.

Cohen, Sol M. Traumatic Arterial Spasm. *Lancet*, 1944, i, 1.

Holling, H. E., McArdle, B., and Another. Prevention of Sea-Sickness by Drugs. *Lancet*, 1944, i, 127.

Births

COSIN.—On March 21st, 1944, to Pamela (née Stebbings), wife of Dr. C. Frank Cosin, 2, Langland Gardens, Hampstead—a daughter.

Marriages

OGDEN—POCOCK.—On February 25th, at Bromley, J. Kenworthy Ogden to Barbara M. Pocock, daughter of Major and Mrs. G. A. Pocock, of Bickley, Surrey.

Deaths

BRYDEN.—On March 20th, 1944, at Rustington, in his eightieth year, Francis W. A. Bryden, M.R.C.S., L.R.C.P., late of Goldaming.

EASTES.—On March 4th, 1944, at Gerrards Cross, George Leslie Eastes, M.B., F.R.C.S., late Director of Laboratories of Pathology and Public Health.

MERRILL.—Reported missing and believed killed during February, Surg.-Lt. Cmdr. Leslie Merrill, R.N., together with his wife and son.

POLLARD.—On March 26th, 1944, at East Leigh, Weston-super-Mare, George Samuel Pollard, J.P., M.R.C.S., L.R.C.P., aged eighty-five yegrs.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

IT is a tradition which dies hard, that the physician is a man who sets himself apart from the sordid bickerings of the world, holding himself aloof from debates and discussions which bear the faintest trace of a political or debatable flavour. It would not be correct though, to think of him, in this traditional light, as a reactionary, for the advancement of the well-being and comfort of humankind is the cornerstone of many a practitioner's Philosophia Medici.

There is good sense and reason in most professional traditions. This withdrawal from affairs probably results from various factors such as lack of time to devote adequate interest to the subject and a false sense of the stability of Society—a sense which has descended from a more secure age, even if it was, perhaps socially unjust. Again, the operation of the unwritten laws of the profession play their part in considering active participation in the redressing of social wrongs as a subtle form of self-advertisement or even considering it to be killing the goose which lays the golden egg !

Members of the medical profession are the only class who really see at first hand the evil consequences of social injustices, and yet very often they do not see the connection between the two. We know that tuberculosis in its various forms is caused by the tubercle bacillus, both human and bovine. Tuberculosis and bad housing with its consequent overcrowding go hand in hand.

We know much about vitamins, but not enough to ensure that everybody gets an adequate supply in the natural form. Again, we as doctors know the minimum amount of food a man ought to have in order that he may live, and yet we cannot help him to have it.

Perhaps these few examples will have shown how indissolubly connected is the knowledge of disease with the knowledge of the conditions of life which affect the ordinary man and woman, conditions which are economical and ultimately political.

Perhaps you consider this last breath-taking inference as rather impudent, but it remains true nevertheless that the solution of several medical problems is very largely political.

We hasten to add that this does not of necessity mean that we should put ourselves up as a prospective M.P. But what it does mean is that we should be at pains to learn of the ways of life of our fellow-men, to understand the conditions of their life and so understand the root causes of many of their troubles. Armed with this knowledge we may then take action if it becomes necessary.

You see, politics in its real Greek sense means citizenship. This is not merely paying your rates and taxes, but involves active participation in communal affairs. So we come round again to the need for a real widening of the doctor's horizon. This can begin now in the student life so that by the time of qualification we shall already know something of *social* pathology as well as our general and special pathology. Pathology is the basis of practical medicine ; we cannot treat unless we can diagnose and we cannot diagnose unless we know why things behave abnormally and the consequences of that abnormal behaviour. That implies knowledge of the so-called normal. Therefore we might justifiably, if pedantically, be termed students of patho-biology !

Anuria: Its Causes and Treatment

A Clinical Lecture delivered at Guy's Hospital, January 27th, 1944, by
A. A. Osman

GENTLEMEN,—It was formerly customary to divide cases of anuria into two main groups—obstructive and non-obstructive. Of recent years, however, it has become apparent that this simple and obvious arrangement is not quite satisfactory, because it has been found that in an increasing number of conditions, to which I shall refer presently, both obstructive and non-obstructive factors combine to cause the anuria. I propose, therefore, to give you the more modern classification as described in an excellent recent paper by Kasten, though in a modified and abbreviated form.

Anuria may be divided ætiologically into four main groups :—

1. Pre-renal or Circulatory.
2. Renal or Excretory.
3. Post-renal or Eliminatory.
4. Combination forms.

1. *Pre-renal or Circulatory Anuria.*—The chief factors in this form of anuria are diminished blood volume and inadequate blood pressure. It occurs with :—

(*a*) Pressure of tumours upon, or embolism of, the main vessels of both kidneys.

(*b*) Diminished fluid intake.

(*c*) Disturbance of blood constituents (water and salts) through severe hæmorrhage, vomiting, diarrhœa, sweating, or heart failure.

(*d*) Retention of fluid and salts in the tissues (œdema formation).

(*e*) Low blood pressure : shock (peripheral circulatory failure etc.).

Inhibitory form or so-called "reflex anuria" which may perhaps be regarded as a form of local shock. Thus, the glomerular pressure in normal human beings is about 90 mm. Hg. If the arterial blood pressure falls below 70–90 mm. Hg., then it will be less than the osmetic pressure of the blood proteins and renal excretion will cease. In renal disease glomerular pressure often falls below normal owing to spasm or obstruction of the afferent arterioles so that a relatively slight fall in arterial pressure will cause anuria. Anuria of this type occurs with :—

i. Inhibition of uninvolved kidney by obstruction in opposite organ.

ii. Spasm of main vessels due to splanchnic stimulation (abdominal surgery).

iii. Peripheral irritation of renal tract—passage of catheters (probably causes reflex fall in blood pressure).

iv. Anæsthesia, general, local and spinal, but especially spinal.

v. Pain.

2. *Renal or Excretory Anuria.*—The main factor in this group is inadequate functioning renal tissue. It occurs in :—

(*a*) Acute nephritis, primary nephrosclerosis (primary granular kidney), secondary nephrosclerosis (chronic glomerular nephritis and chronic pyelonephritis) and, very occasionally in advanced renal tuberculosis, polycystic kidneys and hydronephrosis.

(*b*) Acute necrotising nephrosis—after poisoning with heavy metals, *e.g.*, mercury, gold and arsenic ; after burns and severe jaundice.

(*c*) Pre-eclampsia and eclampsia.

(*d*) Bilateral symmetrical cortical necrosis.

3. *Post-renal or Eliminative Anuria.*—Obstruction to the outflow of urine.

(1) Intrinsic factors :—

Blockage of ureters—bilateral, or unilateral with inhibition of unaffected

side due to calculi, blood clots and (rare) ureteral abnormalities, *e.g.*, kinking and aberrant vessels with trauma and infection.

(*b*) Calculus blocking ureter of only functioning kidney.

(*c*) Lower urinary tract obstruction, *e.g.*, tumours of bladder and prostate.

(2) Extrinsic factors :—

(*a*) Injury or ligation of ureters in pelvic operations.

(*b*) Retro-peritoneal tumours, *e.g.*, carcinoma of cervix.

4. *Combined Forms of Anuria.*—More than one of the circulatory, excretory and eliminatory factors are present. When obstruction participates in this variety of anuria it is usually intra-renal, *i.e.*, it occurs in the renal tubules. The following combination forms of anuria are not uncommon :—(*a*) tubular obstruction combined with tubular degeneration, *e.g.*, sulphonamide poisoning, incompatible blood transfusions and blackwater fever ; (*b*) tubular obstruction and circulatory factors (shock)—crush syndrome ; (*c*) circulatory factors (shock) and tubular degeneration or necrosis—severe burns.

Finally, in severe injuries and rupture of the kidneys probably all these factors participate in varying degree.

TREATMENT.

We are concerned now with the treatment of pre-renal and renal anuria since that of the post-renal variety, except in so far as it is due to shock, is mainly surgical. Treatment is both preventive and curative, and it will be convenient to consider the former first.

PREVENTIVE TREATMENT.

Much can be done to prevent anuria, and often by very simple means, provided we bear in mind the conditions in which it is likely to arise as, for example, after anæsthetics, surgical operations and treatment with such substances as gold and mercury. Subjects with previously damaged kidneys from any cause will tolerate such procedures less well than those with normal kidneys, and will be more liable to sequent anuria. Careful preliminary examination of the patient, and especially of the urine, will often suggest that such treatment, if not imperative, is better avoided. Again, I may remind you that few persons over forty years of age have kidneys which are histologically quite normal. Careful selection of patients for therapeutic measures which are known to be not uncommon causes of anuria is, therefore, an important aspect of preventive treatment.

Often, however, in spite of age and perhaps when there is obvious evidence of renal disease, such procedures cannot be avoided. Even then much can be done to prevent the development of anuria. The best form of insurance against such a risk is an adequate precedent diuresis, and the best means of securing this is to give an ample supply of fluids by mouth. Post-operative and post-therapeutic anuria are comparatively rare occurrences when, for two or three days previously, the patient has passed an average of not less than fifty ounces of urine. If after increasing the fluid intake (exclusive of that contained in the food) to between four and five pints a day (*i.e.*, a period of twenty-four hours), the average output of urine does not reach this value then the alkaline mixture referred to later should be given by mouth in doses sufficient to render the early-morning specimens of urine persistently and mildly alkaline (*p*H about 7.2—7.4).

THE TREATMENT OF ESTABLISHED ANURIA.

Before beginning treatment it is important to remember that many cases of anuria either recover spontaneously or following treatment of the causal condition. It is a mistake, therefore, to be in too great a hurry to adopt measures, often necessarily of a drastic nature, for the more direct relief of this symptom. My own inclination is to defer such treatment until the anuria has persisted for at least forty-eight hours without signs of remission, though sometimes earlier intervention is called for, as I shall indicate presently.

Even when treatment of the causal condition fails to relieve anuria this symptom may often be cured because it so frequently arises from secondary circulatory and other interrelated factors irrespective of the nature of the primary disease. Of these factors, common to the pathogenesis of many examples of anuria, dehydration and disturbances

of the salt-and-water balance of the tissues, are the most important and the most amenable to treatment. In fact, the treatment of the symptom anuria consists essentially of attempts to restore the water and salt contents of the body to normal.

In practice, the degree of dehydration may generally be assessed on clinical grounds. Disturbances of salt balance result mainly, in the present connection, in alterations in the acid-base equilibrium either in the direction of an acidosis or an alkalosis. An estimation of the alkali reserve of the blood will readily determine which of these is present, but generally, except after severe and persistent vomiting, and, perhaps, marked hyperpnœa, anuria is accompanied by some degree of acidosis. In the vast majority of cases, therefore, alkaline salts are required. One further point should be mentioned—namely, that a damaged kidney does not so readily respond to the comparatively sudden introduction of large quantities of fluids into the body as does the normal organ, so that, when possible, it is always wise to give fluids by mouth, or even per rectum, in preference to the intravenous route.

Anuria rarely persists for longer than twelve to fourteen days without causing death from uræmia. During this period the patient is usually too ill to take food by mouth, but *glucose* should be added to the drinks. Sometimes, however, the patient is remarkably free from general symptoms and then a basal protein diet (1 grm. of protein per kilo of body-weight per diem) should be given. A similar diet is needed in the rare instances in whioh anuria persists for longer periods.

When dehydration is obvious and severe the fluid intake should be not less than five, and rarely more than six, pints per twenty-four hours. If dehydration is not apparent a fluid intake of between three and four pints per period of twenty-four hours will suffice.

Except after prolonged vomiting or hyperpnœa the following mixture should be given by mouth at hourly intervals until either the urinary flow is restored and attains a *rate* of not less than thirty to forty ounces per period of twenty-four hours, or symptoms of intolerance (tetany) appear. The rate of urine excretion is determined by catheterisation at six-hourly intervals throughout the day and night. :—

℞ Potassium citrate
Sodium Bicarbonate āā grains xxx
Syr: Aurantii minims xl
Water to one ounce and a half.

The use of the sodium and potassium ions in equal parts is not fortuitous, but I have not the time to go into the reasons now.

When the required rate of urine excretion is attained and is seen to be still increasing the dose of alkali is reduced at first to two-hourly, then to three- and four-hourly intervals, and so on, provided the rate of urine excretion remains satisfactory. If tetany develops this method of treatment must be abandoned and, if necessary, the tetany may be controlled by one or more intramuscular injections of calcium chloride (1 grain in 30 minims of water or saline).

In spite of incessant vomiting acidosis may occur and alkaline therapy will then be indicated. Alkalosis should, however, first be excluded by an estimation of the alkali reserve of the blood. The above mixture cannot, of course, be given by mouth because of the vomiting, but may be given as a 3 per cent. solution per rectum. If rectal therapy is not tolerated a one-sixth molar (isotonic) solution of *sodium lactate* should be given by intravenous drip. The lactate is converted into glucose and the sodium ion appears in the tissue fluids as sodium bicarbonate. Sodium lactate is usually prepared in ampoules of the molar solution and is added (in 1/6 molar concentration) to saline or Ringer's solution for injection.

When anuria is known to be associated with an alkalosis fluids should still be given when possible, by mouth as before, but as vomiting is generally present as well it is more often convenient to give a solution of 5 per cent. *glucose* by intravenous drip at the rate of 50 drops per minute—*i.e.*, six pints in the twenty-four hours. On no account should acid salts, such as ammonium chloride, be given to combat alkalosis.

There is one exception to the use of the potassium ion in the above mixture—namely, when the potassium content of the blood is already above normal. This is likely to occur in renal insufficiency due to chronic Bright's disease and in the crush syndrome. In these circumstances sodium citrate should be substituted for potassium citrate.

I mentioned previously that it is often unwise to be in too great a hurry to begin treatment for anuria. An important exception to this general rule occurs in the treatment of the anuria which sometimes follows sulphonamide therapy and in which blockage of the tubules with crystals of the acetylated compounds plays a part. The formation of these crystals can usually be avoided if the fluid intake is increased sufficiently to ensure that the specific gravity of the urine does not exceed 1.014, but should they develop and anuria result ureteric catheterisation should be performed within twelve hours of the onset of the anuria.

It remains for me to warn you against certain measures which are commonly advocated for the treatment of anuria, but which, at any rate in my experience, are either of doubtful, or of no value. Thus, hot fomentations to the loins, though of little use, will certainly do no harm and may give mental relief. Dry-cupping of the loins is both brutal and futile. Decapsulation, unilateral or bilateral, is frequently recommended and examples of cures are regularly published. Failures are rarely reported. The value of decapsulation for anuria is, in my opinion, unproven though it must be admitted that the outlook is often so grave that even this desperate measure may sometimes justifiably be used.

REFERENCE

Kasten, H. E. *Journ. Urol.*, **1943, xlix, 93.**

"Honour the Physician . . ."

By PHILIP HOPKINS.

TO those who have read much it must have been noticeable how prominent is the criticism of the physician. From the time of the earliest Greek writers until the present day this criticism has been directed at the doctor's ignorance, his greed for personal gain, his not practising what he preaches and his killing more than he cures. What little praise there has been is for his kindness and generosity and, to a lesser extent, for his learning.

In the following examples, which I have collected from the writings of the better known philosophers, poets, playwrights, statesmen and professional men, it will be seen that, despite progress in our medical knowledge, the same things have been said throughout the centuries.

Proverbs should never be taken too seriously, since they are often contradictory, though, unfortunately, I have read and heard only of those less favourably inclined towards medicine, and, where they do seem to be contrary to one another, there is still no improvement in their meaning.

An old Chinese proverb: "Medicine does not kill; the physician kills" is but one of many having the same inference.

One used by Ambroise Paré (1510–90): "God heals and the physician hath the thanks." Another from China: "In a dangerous illness call in three doctors," which does superficially contradict that "One doctor is better than two, but three are fatal."

Despite the great teachings and practice of Hippocrates, the Greek writers were prone to this same sceptical outlook on the physician. In Part II of "The Fables of Æsop" we read that: ". . . There were two Doctors upon a Consultation about a Sick Man, one said he would *live*, t'other that he would *dye*, and in *this interim*, the *patient* marches off and leaves both his Physicians in the Right. *I knew what it would come to*, says the one, and *I could have prevented it*, says the other. As if *life* and *death* were no more than a Chance at *cross* and *pile*, and *physick* only a dealing by *guess*."

Aristotle (384–322 B.C), in his third volume on "Politics," writes: "We are told that a patient should call in a physician; he will not get better if he is doctored out of a book . . . he only cures a patient and takes a fee."

Heraclitus (513 B.C.), writing "On the Universe," says: "Doctors cut, burn and cruelly rack the sick, and complain that they do not get an adequate fee for the benefits they effect in sickness."

If we turn to the Bible we may read that: "A woman who was under an issue of blood, twelve years, and had suffered many things from many physicians and had spent all she had, and was nothing better and rather worse" (St. Mark, ch. v, 26).

And in Ecclesiasticus, ch. xxxviii, 15: "He that sinneth before his Maker, let him fall into the hands of the Physician."

Of the Roman writers few were more bitter than Pilonius Secundus (23–79 A.D.). In his XXIX. book on "Natural History," ch. i: ". . . and yet to speak a truth, there are no lies dearer sold or more dangerous than those which proceed out of a Physician's mouth"; and ". . . and lastly, of their hidden secrets and paradoxes, which forsooth they will not divulge abroad, but for some round summe of money. . . ."

In Ovid's Pontic Epistle, I, iii, to Rufinus, we are told that: ". . . the healing art knows not how to remove crippling gout, it helps not the fearful dropsy."

During the Middle Ages most of the medical practice was in the hands of rather ignorant men, generally in religious orders, but in spite of the latter "qualification" they were still talked of as were the preceding generations of physicians.

Roger Bacon (1214–1294), on "De Erroribus Medicorum," writes: "Medical men are ignorant of simple medicine, and at the mercy of uneducated apothecaries"; and again: "Medical men don't learn to know the drugs they use, nor their price."

Whilst Chaucer, in his Prologue to the "Canterbury Tales," gives a fine description of the mediæval "Doctour of Phisik," including these lines:—

"And yet he was but esy of dispence,
He kepte that he wan in pestilence,
For gold in phisik is a cordial
Therefore he lovede gold in special."

From the fifteenth to seventeenth centuries, when such men as William Harvey, Sydenham, Malpighi, Valsalva, Peyer and a multitude of others were contributing their great discoveries to medicine, Ben Jonson, Shakespeare and Molière, to mention only three of the many writers of this period, whose works contained such criticism as was heaped up against the early Greek and Roman doctors.

Ben Johnson refers to the greed of the physician in chapter V of "The Poetaster": "You make no more haste now than a beggar upon pattens; or a physician to a patient that has no money."

Whilst Shakespeare, in "The Tempest," Act III, Scene I:—

Gonzola; You rub the sore,
When you should bring the plaster. . . .

Antonio: And most chirurgeonly.

And in "Timon of Athens," Act IV, Scene III: ". . . Trust not the physician; His antidotes are poison, and he slays more than you rob."

In France the plays of Molière contained such lines as these, from Act III, Scene III, of "Le Malade Imaginaire":—

Argan; Then, according to you, the Doctors know nothing at all.

Beralde; Oh yes, brother, most of them have some knowledge of the best classics, can talk fine Latin, can give Greek names to every disease, can define and distinguish them; but as to curing these diseases, that's out of the question.

Argan: Still you must agree to this, that doctors know more than others.

Beralde; They know, brother, what I have told you; and that does not effect many cures. All the excellency of their art consists in pompous gibberish, and in a specious babbling, which gives you words instead of reasons, and promises instead of results."

Again, from "L'Amour Medicin," Act II, Scene I:

Lisette; Cannot your daughter die without the aid of these gentlemen? (Four Doctors.)

Sganerelle; Do people die through employing doctors?

Lisette; Indeed they do; I know a man who maintained—and he had excellent reason—that one ought never to say "such a person died of a fever, or from inflammation of the lungs," but "she died of four doctors and two chemists."

In 1699 Ned Ward wrote in "The World Bewitched," the oft-repeated phrase: "Physicians kill more than they cure."

And what of the latter two and a half centuries? Again and again—the same words, but different writers and new ways. Voltaire, writing to a friend in 1760,: "As you are living with a Doctor, it is not surprising you are ill."

On December 20th, 1762, Horace Walpole wrote: "I abhor physicians."

J. R. Solly, quoting Voltaire in the "Cynic's Breviary": "A physician is one who pours drugs of which he knows little into a body of which he knows less."

Casanova (1725–1798), in "My Life and Adventures": ". . . in my opinion, that mankind would be less miserable without either lawyers or doctors."

It is reported that Napoleon, when at St. Helena, said to Dr. Antonio Marchi: ". . . Medicine is a collection of uncertain prescriptions, the results of which, taken collectively, are more fatal than useful to mankind."

Sidney Smith published "The Wit and Wisdom of the Rev. Sidney Smith" in 1886, and as part of the "wit" he wrote: "The Sixth Commandment is suspended by one medical diploma, from the North of England to the South."

"Lord Riddell's War Diary" quotes Lloyd George: "Whilst I was dealing with the Insurance Act, I had much to do with doctors. I found them unreasonable and unruly."

William Osler said that: ". . . There are only two sorts of Doctors: those who practise with their brains, and those who practise with their tongues."

And at the present day on the stage one can see the doctor, characterised by G. B. Shaw as over-dressed, pompous, loquacious and money-grabbing individuals.

I have quoted none of those words in praise of doctors, since they are mostly about the generosity and kindness of the physician, and, after all, these virtues are possessed by many outside as well as inside the profession.

But let us hope that it will not be long before the medical profession in England will set as an example to the world a system of medical practice which will no longer warrant the repetition, or writing anew, of such quotations as set out above.

Let us live up to the belief that Gladstone had of us, when in 1890,, he spoke at the inaugural dinner at the opening of the College here at Guy's: ". . . I believe there are no persons who exercise a greater benevolence than medical men, either in position or money, or more especially in the bestowal of that, which unquestionably is money for them, their time, their thought and their anxiety."

Let us take notice of those words written by Karl Marx: "For thousands of years medicine has united the aims and aspirations of the best and noblest of mankind. To deprecate its treasures is to discount all human endeavour and achievement to nought."

And, finally, let us always remember those three words which are part of Guy's itself: "*Dare Quam Accipere.*"

Visit to the Roman Town of Timgad

Extract from a Letter from LIEUT-COL. H. J. B. ATKINS, R.A.M.C.

WE started off—George Ormiston, the medical specialist, and I—early in the morning with our packs on our backs and each with a book of poems in our pockets. Dropping down to the river from the camp, we forded this and then made our way to the main road on the far side. Here we sat down in the shade and waited for something to turn up. Soon enough a jeep came along driven by an American with one passenger. We hailed them and they were glad to give us a lift. By the greatest good fortune they were going sixty miles on our way and, had it not been for two punctures due to driving too fast in the heat, we should have covered this stage of the journey very quickly. As it was we were well placed for the next stage and, after waiting about an hour at the fork in the road where the jeep had set us down, during which we had lunch, we managed to pick up an American Red Cross car, which took us to X——, which is the limit of the territory occupied by British and American troops. Here we had some difficulty in getting further transport, but eventually managed to find a filthy French ambulance, the driver of which agreed to take us another fifty miles on our journey. The stench inside the ambulance in the hot afternoon was unimaginable and the blankets were infested with fleas and lice. To

cap it all the old crock broke down at the top of a mountain pass, out in the wilds and miles from anywhere. At this stage we had our first piece of great good fortune. We had not been waiting for more than ten minutes when along came four buck niggers in a Dodge truck out on the spree. We told them where we wanted to go and they agreed to take us the whole way there, a distance of some sixty miles ! They might as well go there as anywhere, they said.

This seemed very odd, but was partly explained when one of them turned to me and said : " Say, Buddy, are there any girls at X—— ? " To which I replied that I didn't know. We bowled along at a rattling pace and when we eventually did arrive and they found there was not a soul within thirty miles of the place, let alone any girls, they bore it very philosophically, but just dropped us down and flashed off again in their truck.

It is impossible to describe—without exhausting superlatives. It is certainly the most wonderful sight that I have ever seen, and is said to surpass Pompeii.

Here, set in the mountains, is a complete Roman town, in ruins it is true, but very well-preserved ruins and with paved streets like some English market town. The place itself is about half-a-mile square and must have contained some 10,000 inhabitants. There is a complete and unruined triumphal arch, two temples, a theatre, libraries, baths, houses for rich and poor, a forum and a twenty-five seated lavatory. The streets bear the marks of chariot wheels and there are gutters down each side. Under the main limestone flags which constitutes the surface of the streets run the town drains, so that walking along there a hollow ring to the footsteps and where there are cracks you can push a stick through and scarcely plumb the bottom.

The theatre seats four thousand people and the acoustics are excellent. We declaimed to each other from the stage and George made the first speech, saying how pleased he was to come all the way from Rome to see so many happy smiling faces around him (terrific applause). He had always thought that Rome was the hub of the Universe, but since visiting Timgad he realised that the Romans had much to learn from their African cousins. (Renewed cheering.)

It was most impressive and I wished there had been more people to listen than just myself and the innumerable lizards, who are the only inhabitants of the place and bask in the sun on the hot stones. It reminded me of the passage in " Omar Khayyam " :—

> " They say the lion and the lizard keep
> The courts where Janshyd gloried drank deep,
> And Bahran that great hunter . . . ."

The floors of the big houses were decorated with magnificent mosaics and marble tiles. One dining-room was floored with a mosaic depicting fish, lobsters, fruit, meat, hares and other food all worked into a very fine pattern.

The baths were most elaborate and there was an intricate system of heating by hot air just as at Bath. George and I wandered about the streets in the late afternoon sun and pretended we were Romans. We talked of the scandalous conduct of the Queen of Egypt which led up to the battle of Actium. We deplored the coarseness and vulgarity of the legion—getting drunk all over the place—and we extolled the superior virtues of the Prætorian Guard.

It was getting quite late when we turned our footsteps towards the main road and one more like Mr. Micawber, " waited for something to turn up."

It seemed like ages sitting there all alone and it was beginning to get dusk—a very short dusk in these parts—and we were getting out our ground-sheets and had loaded our revolvers ostentatiously for the benefit of a passing tribe of Arabs intending to sleep out in the open, when, to our great delight, an old French Army truck came rumbling along in the fading light.

We boarded this and it took us forty miles to the nearest town, where we spent a very comfortable night in a surprisingly clean French hotel.

The following morning we waited at the crossroads in the middle of the town for a lift. We had a shoe-shine and George (who is a bachelor aged about forty-five) told the little Arab bootblack that he had five wives and twenty-seven children ! The effect was electric ; other little Arab children were summoned and soon there was a collection of kids about forty strong, all whispering to each other and pointing at George and saying " five wives and twenty-seven children." After waiting an hour without any luck we decided to walk out of the town to a road junction about two miles away, where we thought we might pick something up. So off we went followed by a crowd of excited kids rather like the " Pied Piper of Hamelin." When we got to our fork road most of our retinue had dropped off, but four or five came right along

and sat themselves down on the grass and watched George, who started doing conjuring tricks with some chewing-gum. Hour after hour we waited there, and nothing whatever came along; George exhausted his repertoire; and the kids had loped off, satisfied there was no more entertainment to be had.

You can imagine how worried I was, passing up and down scanning the distant road for some sign of life. George, however, was irritatingly philosophical. He said: "My dear Hedley, what if we have to wait here till five o'clock or until five o'clock to-morrow morning for that matter. This is a very pleasant spot and sooner or later something will come along or there wouldn't be a road here," Then he sat down on the grass by the roadside and recited poetry until I could have knocked his head off. Eventually, to my immense joy and to the accompaniment of George's "I told you so," a shaky contraption containing three Arabs came rattling along. These readily agreed to take us back to the outskirts of the occupied territory and we were driven with great care and dignity back to the same place where we had picked up the French ambulance on the way out. Here we had a very late lunch with some American fliers who were camped out on the plateau and they got us transport for another forty miles of our homeward journey. After that we picked up an American radio car and the last lap of fifty miles was done in great style in a British staff car complete with chauffeur, who was much puzzled by George taking off all his clothes to keep cool. We were set down at the same spot where we had picked up the jeep, and we once more forded the river in the late afternoon, climbed the hill up to the hospital, and flopped down in our tents, having had an unforgettable, supremely enjoyable and most entertaining trip.

Sport

Rugby

GUY'S *v.* ST. MARY'S HOSPITAL.

(*Played at H.O.P. on Saturday, March 4th.*)

Result: Guy's, nil; St. Mary's Hospital, 1 goal, 1 dropped goal and a try (12 points).

Before this game started it was generally agreed that the strength of the St. Mary's backs would turn the game in their favour, and so it proved, but they were never allowed to move with the speed and accuracy with which they had been credited. This was due to the excellence of Guy's forwards, who tackled promptly, pounced on the loose ball, and harassed the Mary's backs into errors. Another contributory factor was the close lying up of our three-quarters, which compelled Mary's to change their tactics midway through the second half and punt to the full-back.

Guy's forwards carried out several fine rushes and thoroughly deserved a try in the first half, when Vidot caught the ball from a rebound, sent Harvey away, who in turn passed to Brittain, but the movement ended in a scrum near the Mary's line.

At half-time there was no score; the ding-dong struggle continued, but the Mary's backs always looked dangerous when finding room to move and, eventually, after fifteen minutes of the second half, Graham ran in for a try from a blind-side movement for Hall to convert. Hall came into the picture again with a beautiful long-range drop-kick, due to a weak clearance by Harris. Our forwards looked on helpless for fear of being off-side. The final score came as a result of an individual effort by Scott, who gathered the ball from a punt ahead and went through unmolested.

It was a big ordeal for J. M. P. Day, an Old Cranleighan, now at Tunbridge Wells; he kept very cool and performed creditably on the right wing. He is well-built and, given opportunity, should improve with experience. D. G. Jones, in the centre, is also gaining confidence and some of his touch-kicking was the model of accuracy. This augurs well for the future. P. C. Matthews was another comparative newcomer to the second row of the pack and no fault could be found with him.

Team.—E. K. Harris; J. M. P. Day, N. K. Macrae-Gibson, D. G. Jones, D. C. Boyd; E. W. Graham, R. N. H. Vann; A. Batty-Shaw, A. B. Lee (captain), I. H. Hilliam, D. L. Gullick, P. C. Matthews, R. G. L. Brittain, C. Vidot, P. D. Harvey.

Association

LONDON UNIVERSITY LEAGUE

SEMI-FINAL.

GUY'S *v.* ST. MARY'S COLLEGE.

This match was played on March 4th on King's College ground and resulted in a win for Guy's by 5 goals to 3.

The game proved to be fast and furious, undoubtedly the best game of the season for all concerned. From the kick-off St. Mary's attacked time and time again. Many a dangerous situation was saved by E. G. Murphy at left back and P. S. Stableford at right half. However, Guy's opened the scoring through M. J. L. Sykes, who returned to the side after playing several games for London University. Soon after St. Mary's equalised, but half-time found Guy's leading 2–1 after a well-placed ground shot by R. Finney.

Almost immediately after the change over St. Mary's equalised, to the delight of their many supporters on the touch line, from a free kick just outside the penalty area. Then Guy's moved R. D. Rogers into the forward line, E. G. Murphy taking his place at centre half. This move was soon rewarded by a goal through C. B. Clarke; R. D. Rogers followed this up with a fine shot just under the cross bar. This appeared to clinch matters for Guy's, but St. Mary's rallied with a further strong attack and scored again. Guy's then made certain of the game, for after some subtle work by R. Finney the ball went out to I. Munro on the right wing, who had made several rapid thrusts during the game; he rapidly made ground and centred to C. B. Clarke, who made the final score 5–3.

Team.—S. Starte, E. G. Murphy, N. T. MacNeil, C. S. Matthews, R. D. Rogers, S. Stableford, R. Owen, R. Finney, C. B. Clarke, M. J. L. Sykes, I. Munro.

LONDON UNIVERSITY LEAGUE
FINAL.

GUY'S *v.* KING'S COLLEGE HOSPITAL.

The match was played on King's College ground and resulted in a win for Guy's by 3 goals to 2.

Guy's won the toss and played against a fairly strong breeze; however, they pressed hard on King's goal for the first ten minutes and were soon rewarded by scoring through R. D. Rogers at inside right.

Guy's were then very unfortunate to lose R. Finney at inside left, owing to a knee injury, for the remainder of the game. King's immediately took advantage and well supported from the touch line scored to equalise. They continued to press, but Guy's held their own even with C. S. Matthews off the field for ten minutes with an injured nose. King's took the lead half a minute from the change-over.

With the score at 2–1 against and with only ten men on the field, prospects of a win were not too bright for Guy's.

With the wind behind them the "ten men" attacked consistently on their opponents' goal and came near to scoring on several occasions. Guy's were soon rewarded and scored the equalising goal from a free kick by E. G. Murphy, which R. Owen cleverly turned into the King's goal. Encouraged by this turn in their fortunes Guy's renewed their efforts and scored the winning goal a quarter of an hour from time through C. B. Clarke, who managed to dribble the ball into the net from a "throw-in" on the left wing.

This is the first time that Guy's have entered for the University Challenge Cup since 1929–30. Guy's won the cup in 1926, when they beat U.C.H. in the final after a replay. Guy's also won the cup in 1920.

We should like to take this opportunity of congratulating the Hockey XI on winning the Inter-Hospitals Tournament.

Team.—A. G. Starte, C. S. Matthews (captain), N. T. McNeil, F. R. M. Young, E. G. Murphy, S. Stableford, R. Owen, R. Finney, C. B. Clarke, R. D. Rogers, I. Munro.

Rowing

The Guy's Hospital Boating Club, since its formation nearly a hundred years ago, has always been small in numbers, but, in spite of a wave-like career, its achievements have been far from small.

For the present season, which began a few weeks before Christmas, a crew has been going out regularly from Putney; twice, the eight resolved itself into a four, and once, the river was fog-bound. Gradually however, the crew began to take shape under the sound coaching of their captain, and now are to be very warmly congratulated upon finishing fourth in 12 min. 21 sec. in the "A" division of the first war-time Head of the River race. Guy's started No. 7 and, after an exciting race, finished half a length down on No. 3.

There were twenty-four entrants for this event, which was rowed on Saturday, March 25th, over a course of three miles from Chiswick Steps to University Stone, Putney. Of the four hospitals that entered Guy's had by far the best time.

It is to be hoped that any men at Guy's next term, who have had some rowing experience, will make every effort to join the Boating Club and so maintain the high standard of yet another of Guy's centenarian sports clubs.

Crew.—Bow, P. A. W. Lea; 2, C. C. Bull; 3, C. W. Williams; 4, J. Bulleid; 5, M. D. Cremin; 6, W. van 't Hoff; 7, T. M. S. Burns; stroke, R. T. Lowein (captain); cox, A. A. W. Fooks.

Hospital Information, etc.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
March, 1944.

Surgery.—E. A. Humphrey.

Pathology, Bacteriology and Forensic Medicine.—E. A. Wright.

Medicine.—A. G. Wolstenholme.

Midwifery.—*A. W. Banks, F.R.S. Knight.

* Has completed the examination.

UNIVERSITY OF CAMBRIDGE.
M.B., B.Ch.—March, 1944.
J. S. Pegum.

CONJOINT BOARD.
FIRST EXAMINATION.—March, 1944.

Anatomy.

L. J. Evered	G. A. Kerr
D. S. Hurwood	J. R. Wallis

Physiology.

A. A. W. Fooks	G. A. Kerr
D. S. Hurwood	J. R. Wallis

Pharmacology.

A. J. Beale	W. M. C. Hallinan
J. F. Cleobury	A. M. Huntley
M. B. Conran	J. D. Huntley
M. W. Cree	M. B. King
E. C. Davies	H. A. R. Loxdale
N. R. Fenton	F. W. R. Seward
G. Forrester	H. W. Topham

The Services

Casualty.

Surg.-Lt. M. C. Cross, R.N.V.R., has been reported missing, presumed killed, in H.M. Minesweeper *Clacton*.

Awards

M.B.E. (*Military Division*).

Temp. Lieut.-Col. L. F. W. Salmon, R.A.M.C.

Births

LAWS.—On April 1st, 1944, to Sheila (née Squire), wife of Lieut. J. O. Laws, R.A.M.C., 13, Forde Avenue, Bromley, Kent—a daughter (Judy Margaret).

BRANGWIN.—On March 21st, 1944, at Guy's Hospital, to Joan (née Hobbins), wife of Dr. P. L. Brangwin—a son (Anthony Charles).

Deaths

GOOD.—On March 18th, 1944, at Blackpool, Beryl Gladys Good, beloved wife of J. Beaumont Good, Ft.-Lt., R.A.F. (abroad on active service), of 75, Bensham Manor Road, Thornton Heath.

LEECH.—Missing at sea in February, 1944, now presumed killed in action, Barbara Elisabeth Leech, Q.A.I.M.N.S. (Guy's 1938–1942), of 52, Park Avenue, Enfield.

OWEN.—On March 29th, 1944, suddenly, at Southport, Owen Owen, L.D.S., R.C.S., of Llandudno.

SOUTH.—Missing at sea in August, 1944, Robert South, L.M.S.S.A., of 23, Church Street, Banbridge, Co. Down.

VENABLES.—On March 31st, 1944, suddenly, at 24, Cranley Gardens, S.W.7, John Frederick Venables, M.D., late of New Lodge Clinic, Windsor Forest.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

REFORM and change have been the atmosphere for months. White papers, reports from select committees, architects' plans follow each other in rapid succession, yet, for a week or two at the most, a new tension has developed suppressing subconsciously all constructive thought. That fearful calm portending great events seeps in every niche. The leaves shiver a moment and are still, rebuked for their nervousness. Below the cattle gather restlessly, scorning shelter from a storm for which no shelter is. Man, when in company, rises to unnatural elation ; when alone, is vacant and morose. It is no time for deep thoughts. The mind flits easily on and back, then away again under the strain of this uncertainty. So, being fresh from company, let the theme be light frivolity till the storm breaks to restore the normal self.

How odd to resent being typical ! No one can conceive himself as being one of a group of like men—leastways this side of the Rhine. " He is a typical Englishman," " a typical student," " a typical medical student." They all rankle a little largely because all defy definition. Is a typical student (medical) one who invariably grows a moustache, wears corduroy trousers and a beard ? Or, conversely, one whose suits are immaculate and hair unruffled ? We have our preference, but will not be drawn. Does he drink a little ? Perhaps we may say he does. Some guarantee distinction between a Guy's student and one from Bart.'s. But most, unlike the Englishman, enter with their eyes at least half open—so why the resentment ? Odd—very odd !

SIR WILLIAM OSLER, in his essay " Books and Men," writes : " But when one considers the unending making of books, who does not sigh for the happy days of that thrice happy Sir William Browne, whose pocket library sufficed for his life's needs, drawing from a Greek testament his divinity ; from the aphorisms of Hippocrates his medicine ; and from an Elzevir " Horace " his good sense and vivacity. There should be in connection with every library a corps of instructors in the art of reading, who would, as a labour of love, teach the young idea how to read." If the author of the " Religio " were alive to-day, his Greek Testament and his " Horace " would still suffice, but his Hippocrates would be a little out of date. Even the text-book of his disciple, Osler, would be strange reading.

But we take Osler's advice to heart about " teaching the young idea how to read," and present in this issue of the *Gazette* a number of reviews of books which have been lately sent to us by the publishers. Take the advice of an old writer about classes of readers : " Sponges which attract all without distinguishing ; Houre-glasses which receive and poure out as fast ; Bagges which only retain the dregges of the spices and let the wine escape ; and Sives which retaine the best onely."

Two misprints were overlooked recently in the *Gazette* for which we make due apology. The Guy's Hospital Boat Club was referred to as the Guy's Hospital Boating Club. We agree the latter smacks rather strongly of punts and picnics, which is far

from the stalwart truth. Then "Sinbad" was allowed to observe that His Majesty's sailors, as penalty for contracting V.D., have their pay stopped. In fact, it is only half so discouraging—they have their rum ration suspended!

MANY Guy's nurses, both past and present, will be interested to hear that a message from a Japanese-controlled radio station in Singapore has been picked up giving news of five old Guy's nurses. It was addressed to the Matron and reads as follows:—

> "Dear Miss McManus: Greetings from five Guy's nurses—Elsie Bullock, Norah Jones, Elizabeth Fitch, Joan Margaret Boston, Barbara Walker. Well and cheerful in good camp."

THE Middlesex Seven-a-Sides almost marked the end of the winter as far as athletic activities are concerned. It most certainly has been a successful season—the Rugby Club's Centenary and their fine showing against the London Rugby Union; the Soccer and Hockey carrying all before them. Rowing and Squash both well to the fore in the inter-hospital events. Yet the numbers engaged have not been great compared with the number now in London. "No, I've given it up because it ties you so completely every Saturday." And as Saturday follows Saturday: "I've seen it before, but there is nothing else on"—and a "bracing" 'bus ride to the Elephant and Castle provides the week's exercise and fresh air. Well, perhaps the first teams are entitled to expect a regular turn-out, but others are more informal. The Secretaries have drafted notices; practices and trials are being arranged. Do help them and avoid those long week-ends with nothing done.

A SCHEME has been launched by the *Gazette* to finance the publication of a short book informally written, giving the story of the Hospital activities during war-time—an account to cover everything from sector administration to the days of the "blitz" on Guy's. The author, who at present must remain unnamed, would appreciate help in getting material for the book. Personal experiences, photographs, accounts of events in the sector would all go to broaden the viewpoint of the book. We do hope that material will be forthcoming and, if sent to the *Gazette*, will be delivered to the appropriate quarter.

WE should like to take this opportunity of congratulating David Stafford Clark, who left Guy's in 1939, on being mentioned in despatches for the second time.

AT the moment of going to press we are told, be it said only as we expected, that Gerald Thomas has passed the M.R.C.P. examination. Many will wish to join us in congratulating him.

Air on the G—'s Strings

(*With apologies to Robert Herrick.*)

WHENAS with strings my Staff-nurse went,
Then, then methought the Fates had sent
A knot for mine undoing meant.

But now when for my love I sigh,
So dull of mind and moist of eye,
There'll be no lovers' knots for aye!

SIR SOFIA BARNACLE.

Obituary

MABEL GRACE BONSOR (1863–1944).

BY the death of Mabel, Lady Bonsor, which took place at The Wildernesse (Guy's U.S.A. Annexe at Seal) on April 11th, Guy's nurses have lost the President of the Nurses' League and one of their truest friends. For half a lifetime Lady Bonsor took an active interest in Guy's Hospital, visiting the patients in Naaman Ward once a week; bringing her little basket of magazines, cigarettes, chocolate, a few flowers, perhaps a few eggs; and, over a cup of tea, talking with Sister Naaman about the needs of any patients who were far from home and without visitors. On those days she always looked into the Office, shook hands with the Assistant Matrons, Secretaries and others; had a word with the Matron, if she were in; and, when she left, she left a heartening and charming atmosphere behind her.

During the days of Sir Cosmo Bonsor's Treasurership (1896–1910) we can chronicle many excellent modern advances that he and the Governors brought about, to place the Hospital on the pioneer footing for which it became so distinguished. A particular benefit to the Nursing Staff—who were at that time badly housed—was the building of the Henrietta Raphael Nurses' Home, opened in 1902, and containing single rooms with fixed basins and hot and cold water laid on for each nurse; a fine common room and other sitting rooms, a large dining hall and gallery and a swimming bath below — the finest and for many years the only Nurses' Home of its kind in Europe. Lady Bonsor, with the Matron, interested herself in every detail of its equipment. Recreation for the Nurses was lacking in the Borough. Sir Cosmo advised the Governors on the project of building a country cottage for the Nurses within easy reach of the Hospital, and in 1899 the "Nurses' Ground" on the hillside at Honor Oak Park was bought, and the Cottage built among some fine forest oaks, which gave it a quiet sylvan air—a haven of peace amid the building estates with which it is surrounded. Year by year gifts from Lady Bonsor, Sir Cosmo and theirf riends added to the Nurses' comfort and pleasure — a marquee, a spacious summerhouse, garden furniture. In later years Lady Bonsor decorated and entirely refurnished one bedroom for the Sisters' use at week-ends and she installed the telephone. Prizes for the competitions in needlework, painting and photography at the Annual League Meetings; support for music, drama and sport; interest in the domestic staff; remembrance of the lodge porters every Christmas—one could go on indefinitely enumerating gifts. Far more endearing than any gifts was her keen personal interest in the workers at Guy's and particularly in the Nursing Staff.

I can well remember, as a junior nurse nearly forty years ago, the yearly garden-parties at Kingswood Warren, when as many nurses as could be spared (in uniform in those days !) went down to Kingswood in a special saloon train which Sir Cosmo, as Chairman of the London and Brighton and South Coast, now the Southern Railway, provided; the drive up from the station in wagonettes and brakes, the lovely grounds, games, music, a pony to ride, and such unlimited strawberries and cream, still remain in my memory of those happy, carefree days. Our gracious host and hostess moving among their guests, introducing, mixing them, making sure that every guest found enjoyment.

In her widowhood Lady Bonsor did not relax her work for Guy's, although it moved into less exacting channels. Only a few weeks ago she promised, as usual, to take the chair at the Annual General Meeting of the Guy's Hospital Past and Present Nurses' League to be held at Guy's on May 5th. Now, on that date at 2.30 p.m. we shall hold a Memorial Service in the Chapel, where the Past Guy's Nurses who knew and loved her can join with the present Staff to pay a last tribute to her memory.

E. E. P. M.

JOHN FREDERICK VENABLES, M.A., D.M.

JOHN VENABLES died suddenly of coronary thrombosis on March 31st. He was a man of great charm and will be mourned by hosts of friends and grateful patients. He was born in 1888 and was educated at Magdalen College School and Magdalen College, Oxford, where he was a science exhibitioner and gained honours in the final school of physiology. From Oxford he went to Guy's, where he did the usual house-appointments and played hockey for the Hospital. He obtained the B.M. in 1913, and the D.M. in 1924 for a thesis on stammering. On August 4th, 1914, he resigned his appointment as R.O. and joined the R.A.M.C. He served first in Egypt, being invalided home on account of an empyema, which he had diagnosed himself three weeks before he could persuade anybody to operate. Venables was one of the original medical officers of Seale Hayne Military Hospital for functional nervous disorders, where he developed quite exceptional skill in treating soldiers with every variety of war neurosis, and where he was immensely popular with his colleagues and his patients. By the end of the war he was a major and second in command of the hospital. During 1920 he was in charge of a hospital for war neuroses under the Ministry of Pensions and also Chief Clinical Assistant in the Neurological Department at Guy's.

In February, 1921, he became physician to New Lodge Clinic, of which he was co-founder, and with which he was connected from the day it opened until it closed shortly after the outbreak of the present war. He was an ideal man for the post, as he was not only a very able clinician, but soon became an expert medical radiologist and biochemist, and he was a remarkably successful psychotherapist. He used the simple methods described by the late T. A. Ross in his *Common Neuroses*, being, like T. A. Ross, a disciple of Déjérine.

Venables made several valuable contributions to medical literature, especially in gastro-enterology and functional nervous disorders. He was a pioneer in the use of the duodenal tube as a means of diagnosis of disorders of the gall-bladder, the paper he wrote with Dr. F. A. Knott on the subject in 1924 being the earliest published in England. His article on anorexia nervosa, which appeared in the *Guy's Hospital Reports* for 1930, gave the best description of the condition since Gull's original paper. He related the history of several severe cases, which he had cured rapidly with a full diet and simple explanation and persuasion without resorting to drugs of any kind. He had the satisfaction of hearing from all of these patients from time to time during the next ten years, during which they remained free from any further functional disorders. In 1923 Venables published the report of a case, in which he had diagnosed the presence of a parathyroid tumour from the general symptoms in the absence of bony deformities, the first time this had been done in any country.

Venables rejoined the R.A.M.C. shortly after the outbreak of the present war. His health prevented him from returning to the kind of work in which he had rendered such conspicuous services at Seale Hayne Hospital, but he carried on in spite of increasingly frequent attacks of angina pectoris until six months ago. He then resigned, but refused to take the long rest he needed, and was appointed medical member of the first of the new Pensions Appeal Boards. His work was greatly appreciated, but the travelling it entailed proved too fatiguing and was undoubtedly the cause of the attack which led to his untimely death.

Venables married Helen Cox in 1914 and had two sons and a daughter. His elder son is an officer in the R.A.F. and his daughter is a W.A.A.F. His younger son, Hugh, a boy of great promise, was beginning clinical work at Oxford when he gave it up to join the Coldstream Guards. He had just been promoted captain and recommended for the M.C. when he died of acute poliomyelitis in North Africa.

A. F. H.

Spoiled Sweet Clover & other Anticoagulants

A Clinical Lecture delivered by Dr. A. H. Douthwaite, M.D., at Guy's Hospital in February, 1944.

GENTLEMEN,—Certain anticoagulants are of use only in the prevention of clotting of blood outside the body. Thus sodium or potassium citrate, oxalate or fluoride fall into this group. Their use is mainly to preserve blood from clotting prior to some chemical estimation which has to be carried out. Sodium citrate is extensively used in a concentration of 0.25 per cent. in the preparation of blood for transfusion. The potassium salt would be unsuitable for this purpose because of the toxic action of the potassium ion.

Powdered potassium oxalate is often used as an *in vitro* anticoagulant. The blood cells are well preserved and blood can thus be collected and transported to more convenient surroundings for cytological examination. Fluoride must not be used for this purpose because the blood cells are disintegrated by it. It is, however, eminently suitable for the preservation of blood to be examined for urea, uric acid, or sugar content; in fact, for the last it is the only satisfactory anticoagulant in that it prevents glycolysis which otherwise takes place in stored blood. Both oxalate and fluoride are too poisonous for use in blood transfusion.

The above substances act by the removal of ionised calcium. They cannot be used to prevent clotting *in vivo* because, quite apart from the specific toxicity of oxalates and fluorides, to be effective they would have to reduce the calcium to a level incompatible with life.

The citrates have no effect on clotting when given by mouth, for they are oxidised to carbonates in the tissues.

ANTICOAGULANTS *IN VIVO*.

The trypanocide suramin (Bayer 205, Germanin) is such an anticoagulant acting by raising the resistance of fibrinogen to coagulation. Various dyes have the same effect.

Other substances, notably hirudin from the leech, act by neutralising thrombin and are known as antithrombic anticoagulants. The greatest advance in the direction of the use of anticoagulants in the living body was made in the discovery of heparin and dicoumarin.

HEPARIN.

Source.—Derived originally from dog liver; recently from the liver, lung and skeletal tissue of the ox. It arises in the mast cells of the tissues. The liver capsule and lungs are rich in it.

Characters.—Methods of purification have produced a crystalline barium salt of uniform potency. If this be treated with ammonium carbonate solution the barium is removed. Heparin is then precipitated with acetic acid, washed with ether, and dried. It is then in the form of a powder suitable for storage. For use, a 5 per-cent. solution containing 0.25 per cent. of tricresol is prepared.

Composition.—A nitrogenous carbohydrate derivative (mucoitin) combined with sulphuric acid as an ester (up to 35 per cent. SO_4).

Benzidine-heparin ($C_{28}H_{44}O_6N_2S_4$) is a compound which is absorbed slowly and thus possesses similar advantages over heparin as does zinc-protamine-insulin over insulin.

Dose.—0.001 to 0.002 grm. (100 to 200 units) per kilo of donor's weight—for blood transfusion. The suggested unit of activity is 0.01 mg. of barium-free material—*i.e.*, 100 units per 0.001 grm.

ACTION.

Heparin delays the clotting of blood if introduced into the body or if added to the blood after its withdrawal. Its mode of action is not fully understood. It possibly retards the conversion of prothrombin to thrombin and certainly has a direct antithrombic activity. Thrombokinase can overcome the action of heparin, not by direct

neutralisation, but by accelerating the prothrombin → thrombin action, so that the amount of the latter exceeds the antithrombic activity of heparin. It inhibits platelet agglutination and thus the formation of thrombokinase.

If heparin be added to blood after its withdrawal in a dose of 5 mgm. per 100 mils the coagulation-time is extended from the normal 4 to 5 minutes to a minimum of 45 minutes—an average of 100 minutes and a maximum of 60 hours. If the interior of the blood-containing vessel is paraffined the clotting may be delayed three to five times longer.

When heparin is injected intravenously in a dose of ½ mgm. per kilo and some blood withdrawn ten minutes later, the clotting-time is raised from 15 minutes to 45 minutes, 1 mgm. per kilo raising it to 1 to 1½ hours. The effect is most marked during the first half-hour after administration; it passes off completely in 1½ to 2 hours. The bleeding-time is unaffected.

Purified heparin is absorbed after subcutaneous injection and acts in a similar way.

Heparin appears to be relatively non-toxic, as much as 4 mgm. per kilo having been given without untoward effect, except for a transient urticaria.

A certain threshold value must be reached before the anti-coagulant action is observed. This is 0.25 mgm. per kilo of body weight. It is this fact which explains the immunity of a recipient of heparinised blood from further bleeding due to the drug, for, on entering the body, it is diluted to below the threshold value.

Benzidine-heparin, owing to its slow absorption after subcutaneous injection, causes a prolonged moderate increase of coagulation-tine—*e.g.*, C.T. fifteen minutes for six hours.

THERAPEUTICS.

Heparin may be used for blood transfusion. The substance is injected into a vein of the donor and blood is withdrawn ten minutes later. For reasons stated it can then be introduced into the blood-stream of the recipient without fear of encouraging further bleeding. The method simplifies transfusion technique, and obviates the possibility of unpleasnt reactions from the use of sodium citrate. Should the donor receive a severe injury within two hours of heparin administration, his condition would be doubly dangerous on account of hæmorrhage from large vessels. Minor injuries would be unaffected as the bleeding-time is not prolonged by heparin.

It is employed to prevent *thrombosis* after operations by continuous administration after a post-operative interval of twelve to twenty-four hours, or it may be so administered in combination with dicoumarin by mouth (*q.v.*). Animal experiments starting with 40 units per kilo intravenously as an initial dose and followed by 30 units per kilo per hour will maintain the clotting-time at twenty to thirty minutes. In man the subcutaneous administration of benzidine-heparin would probably be more satisfactory. Heparin has been given intravenously at the rate of 20 mgm. per hour. This keeps the coagulation-time at about three times the normal. As operations on the female pelvic organs provide the greatest proportion of thromboses and embolism the method might well be tried out here.

Several cases of *bacterial endocarditis* have been treated with intravenous heparin and sulphapyridine by mouth. A priming injection of 1 mgm. per kilo being followed by drip administration of 15 mgm. per hour in normal saline. Not more then 1½ litres should be given daily. The aim is a fourteen-day course. Results have been uniformly disappointing, death usually arising from cerebral hæmorrhage or embolism.

It seems probable that in adequate dosage the condition of *thrombo-phlebitis migrans* might be arrested. Dicoumarin is more suitable. The administration of heparin after the occurrence of coronary or of retinal thrombosis can aim only at prevention of an extension of the clot or of the formation of an intra-cardiac thrombus.

Heparin may be used as an anticoagulant when collecting blood for various laboratory tests (except the Wassermann), provided that the examination will be carried out promptly.

The anticoagulant effect of heparin is antagonised by tryspin, thrombokinase, snake venom and blood transfusion.

DICOUMARIN.

Dicoumarol. 3,3'-methylene-bis-(4-hydroxycoumarin).

Source.—A substance occurring in improperly cured sweet-clover silage. It arises from conversion of coumarin, which is the aromatic bitter tasting substance in sweet clover. It is now prepared synthetically.

Characters.—A white crystalline substance, slightly soluble in water; readily in alkaline solutions.

Historical.—A hæmorrhagic disease of cattle often ending fatally had long been familiar to breeders and veterinary surgeons. Schofield, of Canada, in 1921, traced the source of this to the eating of spoiled sweet-clover. Link, of America, as the result of seven years of research, reported in 1941 on the isolation and synthesis of the hæmorrhagic agent. Clinical trials were started in the same year.

Action.—Spoiled sweet-clover, and thus dicoumarin, produces hæmorrhage by delaying the coagulation of the blood by reduction of the prothrombin content. Under dicoumarin clotting does not occur in cannulæ introduced experimentally into the arterial lumen.

Prothrombin, a protein, occurs in blood plasma in a concentration of 40 mg. per cent. It is converted into thrombin by thrombokinase in the presence of ionised calcium. The liver is its chief source and vitamin K is important to its formation. A reduction of prothrombin concentration to less than 35 per cent. of normal produces a hæmorrhagic state.

Thrombokinase (thromboplastin), a lipoprotein, occurs in all tissues, especially the platelets. It affects the velocity of prothrombin to thrombin conversion and not the quantity.

Thrombin converts 2,000 times its weight of fibrinogen to fibrin. Fibrinogen is produced in the liver.

The prolongation of prothrombin-time by dicoumarin indicates either destruction of prothrombin, or suppression of its action, or inhibition of its formation. The first is improbable because dicoumarin has no influence on the clotting of drawn blood. It has no effect on capillary fragility, bleeding time, hepatic function, blood cells, blood urea, or icteric index. It raises the erythrocyte sedimentation rate and retards clot retraction. After death produced by overdosage the only autopsy changes are those referable to widespread hæmorrhages. Dogs kept on non-fatal doses of dicoumarin sufficient to prolong the prothrombin-time have, over a period of six to seven years, died no sooner than controls. There is thus strong evidence of the non-toxic nature of the drug apart from its specific action.

The normal prothrombin-time is about 15 to 20 secs. Between the time of administration of dicoumarin and the development of prolongation of the prothrombin time there is a considerable interval, *i.e.* from 24 to 72 hours. This lag is the same whether the drug be given by mouth or injected intravenously as the disodium salt. The effect of dicoumarin on the coagulability of the blood takes two to ten days to pass off.

Dosage.—The quantity of dicoumarin to be administered is controlled by the variations in the prothrombin-time. Experience suggests that to be of therapeutic benefit this time should be not less than 35 secs. and not greater than 60 secs. Although the coagulation-time is prolonged its estimation is not sufficiently accurate to be taken as a guide (*vide infra*). On the first day 200 to 300 mgm. are given. On the second day 200 mgm. On the third day the prothrombin-time is estimated. If it is greater than 35 secs., no drug is given on that day. If it is less than 35 secs. 200 mgm. are administered, and so on for the length of the course. It must be borne in mind that there is also a withdrawal lag—*i.e.*, an interval of two to ten days after cessation of administration before the prothrombin-time returns to normal.

Over-Dosage.—Signs of over-dosage are likely to arise if the prothrombin-time exceeds 60 secs. The earliest symptoms are lassitude, malaise, and severe aching in the region of the costo-vertebral articulations. Ecchymosis, bleeding gums, submucous hæmorrhages, hæmarthrosis, and more dangerous complications from involvement of the brain, or viscera, may then arise.

Antidote.—The only treatment for such complications is blood transfusion. This promptly restores the prothrombin-time to normal, although a single transfusion of a pint of blood may fail to do so for more than a few hours. On the other hand, the effect may be permanent. In the former case a second transfusion is rare y necessary,

as there is but little tendency for fresh hæmorrhages to occur provided that the drug be discontinued. Blood must not be more than four days old because of loss of prothrombin. Vitamin K is useless to combat dicoumarin poisoning.

THERAPEUTICS

The main indication for the use of dicoumarin is the prevention of intra-vascular thrombosis or its limitation if it has already developed. It has been used chiefly in an attempt to prevent *post-operative pulmonary embolism*, especially in cases of extensive gynæcological operations. The prophylactic dose suggested by Butsch and Stewart is 300 mg. on two mornings immediately preceding the morning of the operation. It must be clear, however, that a certain danger exists in operating on a patient whose coagulation-time may already be lengthening. Allen and his colleagues, with a wide experience of the clinical use of the drug in about 400 cases, recommend prophylactic treatment to start on the day after the operation. Although it is possible that thrombophlebitis starts whilst the patient is yet unconscious under the anæsthetic, yet the development of a potential embolus of dangerous size probably takes some days. The giving of dicoumarin in this manner is, therefore, justified, but clearly allows a risk of embolism. Probably the safest method is to give the drug first on the morning of the day of operation, then within forty-eight hours it is likely that the prothrombin-time will be lengthened, but this will occur too late to give rise to hæmorrhage at or soon after operation. Further administration must be regulated by prothrombin-time estimations. The drug may be discontinued when the patient first sits out of bed.

Apart from prophylaxis, dicoumarin may be given where pulmonary embolism has developed. The probability of a further embolism is about 30 per cent. and of a fatal one 18 per cent. Prompt use of an anticoagulant is thus indicated. Here the time lag of dicoumarin action has to be considered and it must be clear than whenever evidence of thrombophlebitis has arisen, then the quicker an anticoagulant action can be obtained the greater will be the safety of the patient. In short, in all such instances heparin and dicoumarin should be given simultaneously. The former does not influence prothrombin-time, so that as soon as this reaches the 35 sec. mark, heparin may be stopped. When it is impracticable to give heparin by intravenous drip, from 50 to 100 mgm. may be given intravenously six-hourly for the first two days. The dose for the intravenous injection of disodium dicoumarin is 5 mgm. per kilo, but it has no more rapid effect than when given by mouth, and should be reserved for the rare instances when oral administration is impossible. Dicoumarin must be given for ten days after the onset of embolism or phlebitis.

Other indications for its use are *phlebitis* (post-operative or otherwise), *thrombophlebitis migrans*, *thrombo-angiitis obliterans*, and *coronary thrombosis*, *retinal thrombosis*, and possibly other vascular disorders, *e.g.*, in diabetes until controlled with insulin. In these cases although clotting has occurred the use of dicoumarin is justified in the hope of preventing extension of the initial clot. In thrombo-angiitis obliterans a maintenance dose can be arrived at (usually 100 mgm. per diem) after careful watch on the prothrombin-time for two to three weeks.

There is already impressive evidence of its value in preventing post-operative phlebitis and embolism, notably from Allen, Barker and Waugh.

Contra-indications.—(1) Hæmorrhage.

(2) Subacute or acute bacterial endocarditis because of the already strong tendency to bleed and the renal damage.

(3) Renal disease because the response to dicoumarin is excessive (this applies also to heparin).

(4) When the prothrombin-time is already prolonged—*e.g.*, obstructive jaundice and severe liver disease.

(5) High fever. Must be used with caution because pyrexia increases susceptibility to dicoumarin action.

Results.—The difficulty of assessing the results of treatment lies in the fact that if dicoumarin be given prophylactically it is not possible to say whether it has prevented thrombosis or not. If given therapeutically after thrombosis has occurred it is equally impossible to determine whether an extension of the clot or embolism would have arisen without the drug. Figures of the incidence of thrombophlebitis and of embolism occurring in the surgical wards of large hospitals taken before and after the introduction of dicoumarin treatment are already available and are encouraging. In a few

years the evidence on the matter will be great enough to allow of a final decision to be made.

Lehmann, of Gothenburg, reports nine cases of thrombosis, five of embolism and three deaths in 170 patients subjected to various gynæcological operations in 1941. In 1942 a comparable series was treated prophylactically with dicoumarin, and produced one case of thrombosis and one of mild embolism. The same worker notes that the initial dose of the drug results the next day in a sudden fall of the temperature which usually heralds post-operative embolism and the same effect is seen in internal saphenous or femoral thrombosis and is followed by rapid subsidence of local signs.

In my own limited experience I have found that some patients are very resistant to the effect of dicoumarin in the initial stages. In one such it required a total of 4 grammes given in daily 100 mgm. doses to produce a change in the prothrombin-time. Subsequently it rose to 30 secs. and the coagulation time rose on the same day from 1 min. 20 secs. to 4 minutes. This is unusual and the course of events I have found to be that already described. Furthermore, I have not met with a late development of resistance to dicoumarin such as has been suggested by other workers. In a sufferer from thrombophlebitis migrans, complicated by coronary thrombosis and later by thromboangiitis obliterans the drug was given in 100 mgm. doses daily over a period of 42 days. and the coagulation-time was maintained at 30 per cent. above a normal control. Whereas previously the application of a sphygmomanometer cuff was sufficient to produce thrombosis in the arm, during treatment with the Paevex boot (which is held firmly to the thigh by a tight cuff for two to three hours on end) no such complication arose. One may also meet with unusually high susceptibility to dicoumarin. Recently I found a patient's prothrombin-time had risen to 110 secs. after daily doses of 200, 200 and 100 mgm. The estimation was made 24 hours after the last daily dose. On the following day the time had shortened to 40 secs. The practical difficulty at present is the estimation of the prothrombin-time because thromboplastin extract must be fresh and is not readily obtainable. The coagulation-time is uncertain because its length is affected by so many factors—*e.g.*, temperature. The difficulty seems to be overcome by comparing the coagulation-time of one's own blood with that of the patient, both estimations being carried out in the same circumstances. Dr. Knott, who has kindly assisted me in this manner, has enabled me to use the drug without as yet any untoward results.

Allen, Barker and Waugh have used dicoumarin on 368 patients. In 70 it was given after post-operative embolism, and only one had a second embolus and her prothrombin-time was 25 secs. In 50 there was demonstrable thrombophlebitis, which subsided under treatment without incident. In 129 women subjected to abdominal hysterectomy and treated prophylactically with dicoumarin no embolus occurred. Four had to be transfused on account of hæmorrhage. On 78 patients subjected to other operations the same results were noted. The remainder of the series is made up of a miscellany of cardio-vascular diseases too small in number to justify attempt at appraisement.

QUICK'S SIMPLE CLINICAL METHOD OF PROTHROMBIN-TIME ESTIMATION.

A drop of blood is placed on a slide and mixed with a drop of thromboplastin (thrombokinase) extract. This is stirred with a finely-drawn glass rod and the time of clotting noted. A stop-watch should be used. Normal time : 15–20 secs. Thromboplastin is prepared by mixing 0.3 grm. dehydrated rabbit brain with 5 mils of Physiological Saline Solution and incubated at 50 deg. C. for 15 minutes. The supernatant fluid from which the coarse particles are allowed to separate is used in the test.

Of the extensive literature on dicoumarin the following will be found to be most informative :—

ALLEN, E. W., BARKER, N. W. and WAUGH, J. A. M. A. 1942, 120, 1009.

LEHMANN, J. *Lancet*, 1943, 1, 611.

PRANDONI, A., and WRIGHT, J. BULL. *New York, Acad. Med.* 1942, 18, 433.

QUICK, A. J. The Hæmorrhagic Diseases, Springfield, Ill., 1942.

My thanks are due to Dr. Macbeth, of the Medical Staff of Organon Laboratories, Ltd., for a generous supply of dicoumarin.

Reviews

A Mixed Bag. Recollections and Reflections of a Surgeon. By W. BERNARD SECRETAN, M.B., F.R.C.S. Reading: Bradley and Son, 1943. Pp. 178. Fifteen illustrations. *Price* 6*s.*

MR. SECRETAN'S life has lain in pleasant pastures. Brought up at Purley and Wallington in the 'eighties, when these were still in the heart of the country, he was at Bradfield in the early 'nineties, where he came under the spell of that remarkable little personality H. B. Gray, and was approved, though he may not know it, by that equally remarkable woman, Ma Bullen. Thence to Guy's in the late 'nineties. His memories are chiefly of the surgeons Howse with his spray Jacobson, Lane and Dunn. The only physicians he mentions are Perry and George Newton Pitt, whom he extols for his scientific learning, but hardly for his rounds," having evidently been reduced like many another to a state of collapse by their length. And so on to being H.S. to Lucas, which meant Lane, as Lucas was ill. There follows a chapter on " Last Years of Victorian London," full of reminiscences to the aged and of real history for the young. Then came a unique experience as ship's surgeon to the *Anglia*, which laid a part of the first Pacific cable with visits to Tahiti, Norfolk Island and Fiji, near which he met a cyclone, and shorter ones to Colombo, to Sydney and other Australian ports. Like many another he was bitten by the sea and did another trip, this time the Blue Funnel one to the Far East. Mr. Secretan was one of the earliest motorists and owned his first car in 1905, nearly three years before the Junior Assistant Physician led the habit at Guy's. He then settled down to what was to be his life's work as a surgeon at Reading, where he got on the staff of the Hospital in 1913. He was away for two years at the " Great " War, and succeeding chapters tell of a time in which he first combined general practice (without N.H.I. work) and surgery, but for the last six years surgery only. This work enabled him to take holidays whereby he knows the West and South of England intimately and has " visited pretty well all the interesting places in England, Wales and the Southern half of Scotland, as well as travelling in France, Switzerland, Italy, Norway, Holland, Belgium, Spain, Portugal, Jugo-Slavia, Greece and Turkey, with visits to Cairo and Aleppo. It also enabled him to retire at sixty and go and live in the country at Bucklebury, not far from where he was at school. There he was able to take his part in boating, golf, shooting, fishing and especially hunting. He also kept dogs and had a lovely garden. " In myself," he concludes, " I don't want much except peace, a few congenial interests to keep one's mind active, enough mild sport and exercise to keep one's body fit, and to live among the beauties of the countryside."

T. B. L.

The Peckham Experiment ; A Study of the Living Structure of Society. By INNES H. PEARSE, M.D., and LUCY H. CROCKER, B.Sc. Published by Allen and Unwin, Ltd. *Price* 12*s.* 6*d.*

WHAT is health ? Here is a book describing an experiment designed to find out. Is health something more than the absence of disease ? The doctors and biologists who started the experiment think that it is. To them health is a function, not of physiology, but of biology, not of the individual observed in isolation, but of the individual reacting to his environment.

They thought it reasonable to assume that the family, as the biological unit of society, would prove to be intimately concerned with the nature of health, and planned their experiment accordingly. They designed a building of steel, concrete and glass—in which activities of all kinds could be carried out together. Built round a swimming pool it contains a large cafeteria, in which members can meet, talk and dance as well as eat ; a nursery ; gymnasium ; theatre ; library and rooms for reading, games and working. The partitions are largely of glass so that the main activities of members can be seen from the cafeteria. To this centre, the membership, as a whole, of families within a mile of it was invited for a subscription of a shilling a week. They were given in return a periodic health overhaul, which included comprehensive laboratory tests and the use of the centre and all its equipment, free to the children, and by the adults on payment of a small additional sum for each activity. In general no organisation of the members' activities by the centre staff was undertaken. The facilities were there and members could use them as and when they wished. Thus the staff was able to observe members both by the usual medical methods and in their social activities, and to compare the two.

Their observations are of great interest. The findings of the health-overhauls are very illuminating in themselves. They are set out more fully in a previous publication,* and demand a revision of the current limits of normality. The most striking discovery made was that about two-thirds of the members showed objective abnormality, or *disorder*, without subjective abnormality, or *disease*. The importance of this in the problem of early diagnosis and treatment is obvious. Their observations of the social activities of the members are fascinating. They trace the remarkable development of several representative families from the time of joining the centre to the stage of full participation in its activities. They were able to watch the good effects upon these activities of correcting disorder, and they found that the social development of some members was accompanied by the loss of disorders, such as slight anæmia, for which no explanation had been found.

Thus health came to be conceived, not only as the absence of disorder, but also as the full functioning of a family in adequate surroundings. This theme is elaborated in the first two chapters. It would have been easier to grasp had it been placed at the end of the book after the evidence had been presented. At a time when the Government is proposing to make the health centre the new unit of our medical services we are fortunate to have a book which shows how the use of the word "health" could be more than a mere pious hope.

P. L. M.

* *Biologists in Search of Material.* An interim report of the Pioneer Health Centre Peckham. (Faber and Faber, Ltd.)

Supplement to the Dental Treatment of Maxillo-facial Injuries. By W. KELSEY FRY, P. RAE SHEPHERD, ALAN MCLEOD, GILBERT J. PARFITT. Published by Blackwell Scientific Publications, Ltd. *Price* 21*s*.

THERE is a tendency which must be assumed to be unconscious in books dealing with technical operations, to make a mystery of the subject. The reader is in the position of the conjuror's audience; he is dazzled by the results, but he doesn't quite see how they are obtained. This book cannot be included in that category: the authors show exactly what is up their sleeves and—what is even more informative—they tell us why some of the tricks went wrong.

This book is the supplement to the "Dental Treatment of Maxillo-facial Injuries" and illustrates the applications of the technical operations described in the parent book. Case histories are given in full, sometimes extending over a number of years, together with photographs and radiographs. The cases are classified and the examples described cover the field very effectively. A very interesting section of the book has been written by Mr. McLeod on fractures of the middle third of the face.

A series of micro-photographs illustrates the results of injury and the processes of repair. This section is admirably presented.

The tone of the book is less didactic than that of the parent book, but its assertions are confident and many debatable questions are answered with an air of finality. Great and justifiable prominence is given to the value of the precision lock, the construction of which is so clearly given in the earlier book.

Finally, a small section is given to indicate the scope of the replacement of gross loss of tissue by grafts and by prosthetic appliances.

The authors are to be congratulated on a very worthy companion to their original volume.

J. W. M.

Endocrine Disorders in Childhood and Adolescence. By H. S. LE MARQUAND, M.D., M.R.C.P., and F. H. W. TOZER, M.D., M.R.C.P., Published by Hodder and Stoughton, 1943. 298 pp. *Price* 15*s*.

OF all its branches perhaps the most important is the endocrinology of childhood, for it is often during this period and especially during adolescence that many of the disturbances of the endocrine system occur. It is curious, therefore, that so little has been written up to now on this subject—Engelbach's "Endocrine Medicine," to which the authors pay tribute, is about the only work of any importance which has paid much attention to it. It is, therefore, a pleasure to welcome this new book. It has been written by two busy physicians who have taken a lot of trouble to analyse their diagnoses and given a considerable amount of thought and care to their treatment, and for this they deserve the greatest admiration. Their preliminary account of the

physiology of the subject is succinct and up to date. Their insistence on the due recognition and adequate treatment of the mild endocrinopathies of childhood and adolescence is very proper. Their experience of these conditions is probably more far-reaching than that of other, at any rate, British endocrinologists, and it is, perhaps, a pity, therefore, that they did not set out to write a textbook of pediatric endocrinology, for it would seem that they have the authority to do so. The book, however, is not so much a text-book as a thesis. It relies for its information largely on personal experience and is plentifully illustrated with case protocols. Its contribution to the further knowledge of the subject is considerable, and it should, and certainly will, be read by all who are especially interested in endocrinology. But for the student and for the busy general practitioner this style of writing is not without danger. There is already too great a tendency to attach an endocrine label to a condition ; for instance, Fröhlich's disease or Cushing's syndrome to a case of obesity, and consequently to give a poor prognosis and either no treatment or to dabble maybe harmfully with inappropriate though not necessarily harmless pituitary preparations. The authors, though they very rightly lay emphasis on such essential therapy as diet, speak freely of their own frequently experimental experience of endocrine preparations, often citing them under their commercial names, such as serogan, pregnyl, antuitrin-S, rather than applying to them physiological terms such as serum or chorionic gonadotrophin. This may lead the unwary to argue from the general to the particular and to a promiscuous use of individual preparations rather than to a consideration of the basic physiological deficiency that exists, and of the extent to which it may be met in the isolated case by application of one of the existing proprietary preparations.

These words are intended as a warning to the over-enthusiastic, and it is probable that as such they would be heartily endorsed by the authors ; they are not meant as a criticism of what is an extremely able exposition of a subject which up to now has not received the attention it deserves. P. M. F. B.

Psychological Medicine. By CURRAN AND GUTTMANN. Published by E. & S. Livingstone, Ltd. *Price* 10*s.* 6*d.*

IT is not, perhaps, strictly the province of the reviewer to discuss the wisdom or otherwise of giving yet another book on psychiatry to the world. Nor, if the customer is willing to pay the price (quite a modest one in this case), need one cavil overmuch at the contents or point out that equally good epitomes of current thought and practice can be found in most of the larger text-books of medicine.

The substance of this slim volume is well arranged and a fair balance is maintained between the mass of inchoate and often disconnected theory which forms the background of so much present-day psychiatric thought ; and the severely practical, mostly limited, sphere of treatment.

For, when all is said and done, the therapeutics of insanity—and also to a large extent that of the lesser mental disturbances—remains obstinately empirical and is frequently of only limited value. Lest this should seem too gloomy a view, however, it may be pointed out that much may be done by way of relief of symptoms. And at times a real remission may occur. This last is, of course, the aim of such methods of treatment as insulin shocks, and convulsive therapy by chemical or electrical methods.

These and other procedures, such as malaria therapy in general paralysis ; the modern ideas about epilepsy ; the use of occupational therapy and the need for after care and rehabilitation in the mental sphere are adequately dealt with. The volume is well printed and produced and the illustrations are interesting. J. J. L.

Histology and Embryology. By JOSE F. NONIDEZ. Published by Oxford University Press, 1941.

THIS is a book of a type that was well described by the late T. E. Lawrence. Referring to various systems of transcribing Arabic names into English characters he said : " There are several systems, some of which are very helpful to those people who know enough Arabic not to need helping." Nonidez has stated in his preface that the book is not intended as a laboratory guide, but as a supplement to a text-book. It is extremely difficult to see what useful purpose can be fulfilled by such a work. The majority of medical students have neither the time nor the inclination to study histology profoundly, and the post-graduate who does desire a fuller knowledge will seek the larger reference books or original papers.

In numerous cases very misleading statements are made—*e.g.*, referring to lymph and its cellular constituents: . . . "A few granulocytes (mostly eosinophils) may occur." Granulocytes are rare and eosinophils are not more common than neutrophils. As one would expect from a member of the Spanish School, the sections on nervous tissues are much better than the other parts of the book. The classical errors on the structure of the resting nucleus are perpetuated. Lining networks and chromatin granules are now recognised as artefacts.

The embryological section is perhaps more useful, but again the absence of pictures makes interpretation difficult. The author expects his readers to make their own illustrations on the blank pages included for the purpose, but most students will not feel inclined to do this, and the pages are rather small for the purpose unless the would-be illustrator possesses some artistic skill.

The paper and printing are very good, but it seems questionable whether such a book should be imported in time of war. F. J. A.

Minor Surgery. A Practitioner Handbook edited by Sir HUMPHREY ROLLESTON, Bt., G.C.V.O., K.C.B., M.D., F.R.C.P., and ALAN MONCREIFF, M.D., F.R.C.P. Published by Eyre and Spottiswoode. *Price* 16*s.*

THIS is an addition to the popular "Practitioner Handbook" Series and consists of a collection of articles published in *The Practitioner*. A wide range of subjects is covered varying from minor wounds, the hand and sprains, to the rectum, genito-urinary system and gynæcology; there are useful articles on the "specials"—the nose and throat, the ear and the eye.

There is much elasticity in the conception of the extent of minor surgery held by the various authors—some restricting the work to out-patient operations, injection treatments, etc., whilst others, taking the degree of disturbance and after-effects as a criterion, describe operations such as dilatation and curettage.

As Sir Alfred Webb-Johnson says in his introduction, the emphasis of the book is on general principles. It is not a detailed text-book of surgical handicraft, but it contains much useful information and should be valuable to the student in emphasising the importance of adequate skill in minor surgery and in indicating the many pitfalls to be avoided in such work. R. R. B.

The Care of Tuberculosis in the Home. By JAMES MAXWELL, M.D., F.R.C.P. (London) Published by Hodder and Stoughton, Ltd., 1943. Pp. xii and 105. *Price* 7*s.* 6*d.*

TUBERCULOSIS of the lungs is the commonest infectious disease in this country at the present time and the most important chronic infectious disease affected by war, so that this is an extremely timely little book. It begins by giving an excellent account in non-technical language, so that the patient may follow explanations clearly written, of the nature of tuberculosis, the manner in which infection occurs and factors which influence resistance.

There is very sane discussion on problems with which the patient is confronted: How long he has to be away from work? What is the risk of transmitting infection to others in the home? Is it wise to consider marriage? Is it safe to have children? Can one be cured?

The full importance of co-operation between doctor and patient is stressed. In order to ensure the co-operation of the patient it is desirable that he should understand, right from the start, the principles which underlie the treatment prescribed. It was for this purpose that Dr. Maxwell wrote his book.

Stages of treatment are divided into three: the pre-sanatorium stage, the sanatorium stage and the transition to a normal life. It is with the first and last of these stages with which the book is chiefly concerned. The determining factor in recovery is strict obedience to the rules of general conduct which are set out in the book.

The last part of the book is devoted to the convalescent period with its eventual return to freedom, tuberculosis in childhood and preventive measures, all of which are admirably discussed.

There is a final plea for education of the public to allay ungrounded fears and ignorance as to the nature of the disease and for co-operation between patient and doctor. The medical profession is now tubercle-conscious, and this small book should

be possessed by all those who are interested in the health—physical and mental—of the tuberculous patient.

It should also serve to help all those patients who have to replan their lives because of an attack of tuberculosis. Their problems, worries and questions are anticipated and answered, while the underlying principles of their treatment are explained, so that the necessary co-operation will be forthcoming to ensure arrest of the disease and eventual cure.

G. R. W. N. L.

The Diagnosis and Treatment of Diabetes. (Fourth Edition.) By W. WILSON INGRAM, M.C., M.D., F.R.A.C.P. Published by Angus and Robertson, Ltd. Pp. 146. *Price* 6*s.* 6*d.*

IN the long run what the diabetic patient can be taught to do for himself will count for more than what is done for him. It helps relatively little to save a life by successful treatment of an attack of diabetic coma, unless before the patient be dismissed he has learnt how to live healthily and happily. First and foremost, therefore, is this instruction of the patient in what he has to do for himself or, in the case of a child, instruction of the parents. This course of training must be thorough, and where the physician does not have the time to educate these people himself, or lacks the training necessary, one of the many manuals on the subject is satisfactory. Ingram's "Diagnosis and Treatment of Diabetes" contains directions and charts for preparing diabetic diets, diet sheets which provide predetermined amounts of foods for diabetics on both modified (zinc-protamine-insulin) and unmodified (regular or soluble) insulin, and explicit directions about the use of insulin and the avoidance and treatment of complications. Though this little book is of especial use to the general practitioner it is so clearly written that intelligent patients can derive nothing but benefit from mastering its contents. For, in the words of that great authority Joslin: "There is nearly enough knowledge to-day for the adequate treatment of diabetes, but it needs more general and more intensive application and the development in the patient of a deeper sense of his own responsibility for his care. Coma should be abolished, gangrene halved, tuberculosis prevented, pregnancy in suitable cases made safe . . . the ultimate goal being the avoidance of death in any way due to the disease."

G. R. W. N. L.

Correspondence

NEWS FROM OUTSIDE WORLD.

To the Editor of the GAZETTE.

SIR,—As students we can have little idea of what happens to us and what difficulties we have to meet after we have been called up. During our training we do not meet those who have gone out into the world before us to relate their experiences. We must, therefore, rely upon such letters as those written by "Sinbad," informing us of things which are obvious to any sailor, but far from obvious to any man who is put on a ship for the first time in a position of responsibility.

I only wish that people with outside experience in the Services would realise how helpful and greatly appreciated their letters are.

Yours, etc.,

NIGEL G. NICHOLSON.

Guy's Hospital, S.E.1.

VENEREAL DISEASE.

To the Editor of the GAZETTE.

SIR,—In view of the great increase in venereal disease we are gravely concerned that the dressers in the Annexe may carry out the whole appointment without seeing a single female case. We consider that a total of one and a half hours are totally inadequate to learn the diagnosis and treatment of these important diseases in the female and we would welcome greater facilities.

Yours, etc.,

H. W. TOPHAM, D. J. DENNISON,
C. MONTAGUE RUBEN, J. LEDERER.

Guy's Hospital, S.E.1.

NATIONAL HEALTH SERVICE.

To the Editor of the GAZETTE.

SIR,—I am afraid that your correspondent, Mr. J. D. Wallace, has fallen into an error which is all too common among the opponents of a National Health Service.

There can be no dispute about the basic aim of any changes we may make in our plan of campaign against ill-health. This aim, full as it is of superlative phrases, has been so often repeated of late as to become tedious, but I enunciate it again because it is from this agreed principle that Mr. Wallace and so many others have drawn what I contend to be a fallacious deduction. Our aim should be to provide for each and every man, woman and child in our land the very best medical attention of which our skill and knowledge is capable, and to direct that attention, not only against established disease, but towards the maintenance of the highest possible standard of physical fitness.

I dispute from the very outset the ability of the present medical system to fulfil this principle. Until such time as the adequacy, or otherwise, of medical treatment is entirely unconditioned by financial considerations, until the gallant general practitioners have been united into a fighting army with every modern weapon for the combat of disease and the preservation of health at their command, until the doctor is no longer a potential worker for twenty-four hours a day, until a host of matters concerning the housing, feeding and working conditions of our people have been recognised as vital concerns of any competent health service, then and only then can we set off towards the goal which we have set ourselves.

And I repeat that the present system, insisting as it does on the complete independence of the practitioner and giving to those that can pay what it denies to the less fortunate, is incapable of taking us one step farther along the road to that goal.

How inconceivable, then, seems to me Mr. Wallace's suggestion that we should allow the old to compete with the new when only the new offers any hope of fulfilling our ends. There is no comparison, let alone competition, between the two.

Finally, Mr. Wallace suggests that we are to be burdened with an "inhuman bureaucracy." Very many now-established reforms have had this criticism levelled at them in the past—and have survived. It is, I always feel, the last ditch into which the opponents of any change can creep. I will only say that if the coming changes impose irksome restrictions on the medical man, if he finds himself practising in Manchester when he would have been in Mayfair, earning £1,000 instead of £1,500, then such will be the benefits which the new way of things will bring to those to whom he ministers, that there can be no doubt in his mind which way his duty lies.

Yours, etc.,

IAN A. H. MUNRO.

Guy's Hospital, S.E.1.

? £1,500 ! !—ED.

AN APPRECIATION.

To the Editor of the GAZETTE.

SIR,—May I be allowed to encroach on the hospitality of your pages for a purely personal matter.

I want to express my very sincere thanks, and those of my wife and Miss Winter, to the students who have from time to time been residents of Sherwood Park, for their magnificent gifts. We very much appreciate these permanent reminders of the years spent in Tunbridge Wells, but even more do we value the thoughts which prompted them and the friendships we were privileged to form. Thank you.

Yours, etc.,

H. B. FENN.

Sherwood Park, Tunbridge Wells.

Sport

Rugby

HOSPITALS SEVEN-A-SIDE COMPETITION.

(*Played at Richmond on April 15th*, 1944).

Won by St. Mary's Hospital, who beat Middlesex Hospital in the finals by 5 points to nil.

Guy's beat King's Hospital in the 1st round; (9–0); Guy's beat St. Thomas's in the 2nd round; Guy's lost to Middlesex Hospital in the 3rd round.

Excellent play by the backs interspersed with some clever passing movements and almost faultless defensive play gave Guy's an easy time in the first two games, although

there were some anxious moments in the first game against King's. Guy's were definitely superior in the forwards, and some excellent hooking by Lee gave the Guy's backs most of the ball.

In the semi-finals, when Guy's met their old opponents Middlesex, the forwards were more evenly matched, and after a heavy rainstorm the Guy's team did not appear to have such control of a slippery ball as their opponents, so that the Middlesex backs were given some easy chances. The end came when Boyd was injured and was unable to show his usual turns of speed.

The competition was brought to a close by an exciting game between St. Mary's and Middlesex. St. Mary's won by one goal to nil, scoring during the second half. Middlesex put up a grand fight and there was but little difference in the play of the two sides.

MIDDLESEX SEVEN-A-SIDE COMPETITION.

(*Played at Richmond on April 22nd*, 1944.)

Won by St. Mary's Hospital, who beat R.A.F. Jurby in the finals by 15 points to 5.

Guy's were again beaten by the runners-up after beating the R.A.A.F. by 8 points to 3. The play throughout was a great improvement on that of the previous week, although Boyd and Graham were unable to play. Their places were taken by Jones and Dwyer, to whom much of the credit of the Guy's victory must be given. Guy's played well together as a team and lacked only in practice and finish.

Hockey

HOCKEY SIX-A-SIDES.

(*Played at King's College Ground on Saturday, April 1st* 1944.)

Guy's First VI managed to get through to the final without grave challenge. In the final against the London Hospital, Guy's scored two early goals and then allowed London to equalise. We won by a corner—a rule peculiar to six-a-side hockey. But more than this: the 2nd VI came within a fraction of also being in the final. An untimely bump and the ball went wide of the open London goal. Our thanks are due to Reg. Kerslake for organising such a successful afternoon and for getting together the United Hospitals XI, which drew with the Civil Defence last week and in which three Guy's players took part.

Teams.—"A": B. H. Prideaux, L. D. Carton-Kelly, P. T. Parr, T. C. L. Parry, J. R. Burt, D. R. S. Saunders.

"B": D. C. Dawson, K. W. Bolt, B. G. Oakenfull, G. Thompson, J. P. M. Bensted, G. R. Wotton.

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.

SECOND EXAMINATION FOR MEDICAL DEGREES.

J. J. Ashken
R. L. H. Barnard
R. H. Browning
A. A. Collis
M. P. Coplans
D. O. Davies
D. H. Forsdick
H. Goldschmidt
P. R. Harben
S. J. Harris
J. L. Hayward
J. M. Holmes
J. S. Jones
J. V. Kilby
M. Kugler
E. L. W. Leiser
H. W. G. Loudon
J. E. Mandel
J. D. Oriel
D. M. Rahilly
K. J. Robinson
P. R. M. Scales
D. J. Sheerboom
J. G. Stebbing
J. A. Stewart
J. A. Turner
D. G. A. Westbury
I. Yentis

Change of Address

A. E. Preston, L.D.S., R.C.S., 1, Poole Road, Bournemouth.

R. T. Parkin, Lieut., R.A.M.C., R.C.A.G.K., A.P.O. 6335.

H. Min Sein, Lieut.-Col., I.A.M.C., 7716H (I.T.), India Command.

Change of Name

Jack Albert Orchover, L.D.S., R.C.S. (1940) to John Orchover Forrest, F/Lt. (D), R.A.F.

Appointments

Colonel (local Brigadier) G. Covell, C.I.E., V.H.S., I.M.S., has been appointed Honorary Physician to the King.

Awards

M.B.E. (Military Division).

Captain S. D. Stock, R.A.M.C., has been awarded the above decoration in recognition of gallant conduct in carrying out hazardous work in a very brave manner.

Mentioned in Dispatches

Captain B. S. M. Palmer, R.A.M.C.

Casualties

Missing, believed Killed.

Surg.-Lieut.-Cmdr. L. Merrill, R.N., has been reported missing, believed killed, on active service.

Ievers, Eileen M., A.R.R.C., Matron Q.A.I.M.N.S. (Guy's 1918–1921) in February, 1944, reported missing, now presumed killed in action.

Wounded

Captain B. S. M. Palmer, R.A.M.C.

Deaths

BONSOR.—On April 11th, 1944, Mabel Grace Bonsor, widow of the late Sir Henry Cosmo Orme Bonsor, aged eighty years.

HUGHES.—On March 6th, 1944, William Hugh Hughes, M.B., C.M. Ed., B.Sc., Ashton-under-Lyne, Lancs, aged seventy-nine years.

PENNELL.—On April 4th, 1944, at Moreton-hampstead, George Herbert Pennell, M.D. Oxon, F.R.C.S.Eng., aged eighty-three, formerly of Buenos Aires.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

WHEN we begin the study of Medicine we are often taught to compare disease with war, to look upon infection as an invasion of the body tissues by bacteria. The comparison goes quite a long way to help the understanding of these pathological processes. But we may also reverse the process and draw a few lessons about war from our studies of disease and observations of the progress of ill-health in an individual and in the community.

Part of the physician's job in treating a particular case under his care is to form some idea of the progress and after-effects of the illness. This we term "prognosis." The patient or his relatives may want to know how he is going to take his place again in society, and what measures should be adopted. Should he go away for a holiday to regain his strength, should he take life gently or must he restrain his activities? These and a thousand other questions will be asked, and rightly so, by the patient, eager and intelligent to become a useful member of society once again.

One must judge the skill of a physician, not by the number of patients he manages to keep from the post-mortem room, but by the number he can help to return to their previous mode of livelihood. A commonplace remark, you may say, but true all the same and worth repeating.

Now this world is sick—mighty sick. (The pathology of the condition is for the theologians and economists to explain. The treatment is—well, difficult!) The immediate life-saving measures, however, are terribly important and must be applied with vigour and intelligence lest this relapse of humanity prove fatal. That is to say, the very moment this war ends—and even now as we write—tremendous problems will arise, chief amongst which will be the establishment of some form of medical relief in the countries devastated and ravaged by the pestilence of war. It is no use pretending that it will not be necessary. It is one of the most pitiful tragedies of war that the trail of destruction which it leaves is so wide and far-reaching. We have some precedent of the magnitude of the problem from the state of affairs existing in European countries in the years immediately following World War I. For instance, in Russia, during 1919–22, there were approximately 10,000,000 cases of typhus fever, with 3,000,000 deaths, in a population of 120,000,000. Again, figures for malnutrition, though difficult to assess, show that in Vienna in 1921, of 200,000 schoolchildren examined, 46.7 per cent. were "extremely undernourished," and 50 per cent. were classed as "undernourished." There were many other conditions which showed alarming and dangerous rises in incidence and mortality, such as tuberculosis, malaria, rickets, rabies, and venereal disease. These rises, of course, must be expected again and, in some cases, we are already seeing them.

We are accustomed, in hospital practice, to dealing with cases individually and we can achieve a certain measure of success since all the accessory factors necessary for recovery are there, and we can supervise personally the course of treatment. But post-war medical relief demands a new conception of thought, for we are here dealing with undernourished, frightened and ignorant masses returning to their homes, migrating in thousands in search of food and carrying disease with them.

Mass psychology prevails and treatment must proceed along these lines. The secret of successful relief work lies, therefore, in team-work and organisation.

The effort to provide relief is not only a humanitarian one, but is also designed to prevent the sowing of the seeds of revolution and anarchy, which take root so readily in a people with empty bellies and hungry minds. National Socialism was nourished by the bodies of those who died of hunger and disease in the streets of Germany. But relief must not be used as a political tool to bend a people to a particular ideology. That is why so much useful work can be done by voluntary relief societies supplemented by the larger resources of the United Nations.

Finally, let it be said to those of us who feel a sense of shame that they have not so far borne arms in this tremendous cataclysm, have not shared the toils and perils of war, that our turn comes when the thunder of guns ceases and the smoke clears, that then is the time when we shall help to mollify this fever of the world.

For nearly five years now the Medical School has been a sojourner in foreign parts—to wit, Tunbridge Wells. There the pre-clinical students have been able to introduce themselves to their studies in the pleasant surroundings of an English country town. Admittedly much of the work has had to be done under make-shift conditions and in queer places, but the smoothness of the transition and maintenance says a great deal for the work of the staff and their helpers. Our thanks to them.

Those of us who are up here now can look back upon their time at Tunbridge Wells as an experiment in medical education, for it may well be that some sort of regionalisation of medical schools may result in the post-war world. There are many advantages but we should like to hear the views of students on this matter now that the experiment is at an end. Our teachers will also have some valuable information on this point, and we hope to hear from some of them an outline of the time spent at Tunbridge Wells, together with its humours and excitements in the Battle of Britain, and to see if it has really been worth while from the educational point of view.

Meanwhile, the preclinical students are all back with us in London. We extend a warm welcome to them and hope that they will soon make themselves at home and join in the student life such as it is.

It is indeed pleasant to see all the laboratories and lecture-theatres in the Medical School bubbling with life again, and we hope that the rest of the hospital will soon be similarly imbued with life and activity.

A memorial service for the late Lady Bonsor was held in the Hospital Chapel on Friday, May 5th, and was attended by many friends of Lady Bonsor and of the Hospital who had come to pay homage to one who had given so much of her energy to the Hospital.

Our attention has been drawn to a misprint in the last issue of the *Gazette*. In the review of Mr. Kelsey Fry's book on maxillo-facial injuries, Mr. McLeod is mentioned as having written the section on fractures of the middle third of the face. The author should have been Mr. McIndoe.

Owing to war-time difficulties in the purchase of new books, we have been asked by the Red Cross Librarian if some of our readers could furnish the Hospital with a few of the books listed below, as they are always in such great demend. If you can spare a volume or two from your bookshelf, we should be very grateful to receive them in the *Gazette* Office :—

A. J. Cronin : " The Citadel."
Leslie Charteris : " Anything."
Winston Churchill : " Marlborough " and " War Speeches."
Eve Curie : " Madame Curie."
H. W. Van Loon : " The Story of Mankind."
Pepys' " Diary."
Lord Wavell : " Other Men's Flowers."
Tolstoy : " War and Peace."

Contact Dermatitis

A Clinical Lecture delivered at Guy's Hospital Medical School by L. Forman, M.D., F.R.C.P., on December 16th, 1943.

GENTLEMEN,—We are to discuss to-day the important group of contact dermatitis cases which, I think, are becoming more numerous of recent years. Perhaps this is not surprising in view of the number and variety of the new chemicals which are offered us as medicaments, as colouring agents, or serve the many industrial and domestic needs. So frequent are the reactions of the skin to external irritants that when confronted with a case of dermatitis or eczema one first endeavours to find an external cause before considering internal factors. Certainly the more time one spends enquiring into the habits of the patient, the work he does and the substances he handles the more often one can track down the offending agent. Again, the history of the eruption, the sudden appearance, the duration of two to three weeks, the frequent relapse may be suggestive of an external irritant. The distribution of dermatitis may suggest at a glance that there is an irritant in contact with the skin, in an article of clothing for example. All your patience and persistence in questioning about the details of the patient's activities at home and at work may be needed, and in the end the finding of the offending agent may depend on luck.

The wide range of substances to which the skin is sensitive will be illustrated by a glance at any text-book. Thus, numerous plants, flowers and vegetables—for example, celery—are listed. Then there are the medicaments used in treatment, many of which are capable of provoking reactions. The production of a dermatitis following the use of mercury, tar or sulphur ointment will depend in part on how long or in what strength these substances are used in ointments or lotions.

There are a small proportion of cases, however, who react after a few days only to mercury resorcin or sulphur, in concentrations usually well tolerated. Again, if confronted with a patient who has a long standing or even a generalised dermatitis, with relapses from time to time, it is necessary to consider whether the patient has become sensitive to his favourite ointment, used, it may be, for some time with previous benefit. It should be remembered that chemicals used in ointments or for colouring cosmetics are not always constant. Tars differ, dyes vary in chemistry even though the tint is the same, and the ointment bases may be changed and allow of altered availability of the substances they contain and allow of increased absorption by the skin.

Thus, not infrequently, a patient may be sensitive to one particular lipstick and not to others of the same make and number. Many chemicals, if presented to the skin in sufficient concentration, will act by direct toxic action and provoke an inflammation. Many others do so in less concentration after a period of some five to ten days. This applies to iodine, picric acid and sulphonamide. The latter drug in a 10 per cent. ointment will cause an acute vesicular dermatitis in some 10 per cent. of cases if used longer than ten days. This period necessary before sensitisation occurs has been shown experimentally on animals with primula extract, which was used by Bloch, and is a relatively simple and pure chemical. After seven to twelve days painting on the skin, 95 per cent. of the animals showed a skin reaction which extended over the whole surface of the epidermis. Some chemicals have been shown to unite with the protein of the epidermis to make a definite antigen, and antibodies or, more properly, reagins can be demonstrated in the blood. The serum of the sensitised patient injected into the skin of a control will render the injected area sensitive to surface application of the sensitising chemical. This has been demonstrated, using atropine. However, this circulating reagin has not been demonstrated in all cases of contact irritants. One area only of the skin becomes sensitised. Although the irritant, for example, the nickel plating of a wrist watch or suspender, is removed when the patients ceases to wear it, the area of skin may continue to irritate and show signs of dermatitis and become thickened due to rubbing, or weep at times. This is, perhaps, more apt to occur in those individuals who are allergics, and give a history of eczema in infancy or childhood and asthma in young adult life.

What are the usual clinical findings in the contact dermatitis ? Typically much redness and swelling of the skin and the formation of large numbers of vesicles irregular in size and shape, appearing within twenty-four hours over a particular area of skin. The outline of the inflamed patch will conform sharply to the area where the irritant

is applied. The response to some applications may occur within a few hours and where sensitisation is not so severe the skin may redden only, and, within a few days, scaling will follow and the reaction subsides.

Certain areas of skin react more readily where the horny layer is thin, or where the skin is greasy or moist with sweat. Thus, where the irritant is a dye in clothing—*e.g.*, in a shirt—there will be a dermatitis of the anterior and posterior borders of the axillæ, across the lower part of the back and often most marked over the genitals.

Munition workers handling mercury fulminate and tetryl, as powders, may develop a conjunctivitis and dermatitis of the upper eyelids, lobes of the ears and sides of the neck, areas where dust clings. Remember that although reaction may develop at the site of application it may extend over the whole of the body.

An interesting example was seen in a child of eight years, admitted for a generalised severe weeping dermatitis, fever of 103 deg. F., and albuminuria. After ten weeks she recovered and, after discharge, the mother used the same mercury ointment on the chin, which provoked within a few hours an acute vesicular dermatitis. The same generalisation may occur with flavine and sulphonamide dermatitis. When sensitisation has occurred, it may persist for years. It is always worth asking a patient before prescribing if he has any reason to suspect that he does not tolerate iodine, sulphonamide, etc., and so avoid an undesirable reaction.

The illustrations which I show include reactions to various antiseptics, nickel, rubber, leather and some flowers and dyes.

Respirator dermatitis is easy to detect—a dermatitis of the forehead, cheeks and chin where in contact. Many cases had been traced to one particular batch of rubber, and one chemical used as rubber improver is a known irritant. The rubber in elastic gave a reaction in the case shown, over the areas of the back where in contact. The areas of dermatitis on the thighs under suspenders, due to nickel plating, are not uncommon.

The picture of a man demonstrating an acute dermatitis of the forearms provoked by turpentine reveals the more severe involvement of the antecubical regions where the skin is thin and the irritant is likely to cling.

An illustration of acute dermatitis of the left orbit, and lobe of the left ear and adjoining cheek in a man, who also had a vesicular dermatitis of the first two fingers of the left hand, which was shown to be due to sensitation to the phosphorus sulphide present in the heads of self-striking matches. He kept the box in the left-hand trouser pocket and had the habit of holding his face in his left hand while sitting, transferring the irritant to the face. Application of the match head to the forearm provoked a small area of dermatitis.

Dermatitis over the tops of the toes and sides of the feet may be provoked by the dye in shoe leather.

An illustration of a lipstick dermatitis, proved by application to the chest, illustrates the point made previously. She had been using the same make for some time. A new lipstick gave rise to dermatitis ; another lipstick of the same make and colour was tolerated.

I have no pictures of a flavine dermatitis, but have collected eight cases during the past few years and, no doubt, other cases have been undiagnosed. Flavine is an efficient antiseptic widely used and in general it is well tolerated, but it is not recognised as a potential irritant and sensitiser.

The first case was a medical orderly who had used flavine at his duties for several years. He had had six attacks of dermatitis on the arms, each attack lasting two months, and it was suggested by the medical officer that he was flavine sensitive. He then developed impetigo and applied flavine to the face with a resulting acute and severe facial dermatitis, extending to the neck and arms. The next patient used flavine over the wrist, where recurrent boils had developed. After three months of use an acute dermatitis developed over the wrist and arm. In another man an acute dermatitis over the arms, thighs and genitals followed the use of flavine for several months.

The next two cases were two staff sergeants in the Air Force who had been in the Service for many years and were on the point of being invalided out because of long-standing and relapsing dermatitis. One of these men had in 1942 abraded his leg and had flavine applied for twenty-five days. A dermatitis appeared over the leg, cleared

after several weeks and relapsed from time to time. He had noticed that the flavine had soaked through the dressings and stained his socks and clothes. Flavine is a dye and becomes firmly attached to wool. The socks he was wearing had been washed very frequently during the past year in soap, or soap powders containing soda and emulsifiers. However, this will not detach flavine. It can be dissolved out in 25 per cent. sodium salicylate, and the solution of the sock deposited yellow crystals which were thought to be flavine. A small area of sock applied to the skin of the forearm for twenty-four hours gave a positive reaction. Thus this patient was continually exposed to the irritant. Presumably extra time of contact or sweating and friction would be enough to precipitate another attack. The last case of flavine dermatitis developed an acute spreading dermatitis of the arm after application of flavine dressings for ten days. Flavine was applied as a test to a small area of the chest wall, but with a negative result. However, while in the ward he developed a septic toe. This was dressed with flavine and, where the dressing was in contact over the toes, an acute dermatitis developed after six days.

Reference has been made to the " patch test " when investigating a case of contact dermatitis. Such tests are not without danger, for occasionally some patients are so sensitive that the application of even a small amount of the original irritant to a half-inch square area of skin may provoke a widespread reaction. The usual practice is to apply the substance to be tested to a small square of skin directly, or on a square of cotton which is applied to the skin under a disc of cellophane secured to the skin with strapping.

Some clinics test as a routine each patient with a standard range of known irritants and these are used in concentrations known to be tolerated by most. Details may be found in the larger text-books.

Should the patient complain of irritation under one of the patches or if a reaction is visible through the cellophane, the test patch is removed at once. The patches are removed at forty-eight hours and any reaction noted. The response may range from a few follicular red papules to erythema and acute vesicular dermatitis. It is always worth keeping the sites of the skin tests under observation for a week for reactions may be delayed until sensitisation develops. This has been found with the patch tests in cases of respirator dermatitis with rubber and flavine. The tests are carried out usually on the forearms or across the back, and positive results indicate that the whole skin is in a reactive state or will readily become sensitive.

It will be appreciated that such a general sensitisation need not necessarily occur, the reagins remaining fixed to the epidermal cells at the area of original dermatitis. A more accurate test would be to apply the suspected irritant to the area of skin originally inflamed, but if positive the reaction might be undesirably severe and prolonged.

The White Paper—A National Health Service

Some Observations by George F. Buchan, M.D., F.R.C.P., D.P.H., Lecturer on Public Health ; Medical Officer of Health, Willesden.

THE Government have issued their White Paper on a National Health Service. They state that the proposals made in the Paper are submitted for free examination and discussion by all interested parties and that they would welcome constructive criticism. The intentions of the Government, as stated in the White Paper, require careful scrutiny by the medical profession, especially by the younger members, as well as by those who are about to qualify, as the National Health Service will no doubt fashion the practice of medicine for years to come.

The White Paper is called a National Health Service, but there is very little in it about health. The maintenance of health is a complex process. It is the family doctor who should be in the front line in this matter. The maintenance of health implies, not only a knowledge of the physical and mental state of the individual, but knowledge of the background, the environmental, industrial and social conditions under which he works and lives. If improvement in national health is to be achieved the general practitioner and consultant must know these conditions and assess their influence on health and illness. Many of these environmental matters and social circumstances are brought to light by sanitary inspectors, health visitors, hospital

almoners, members of local authorities and by the public themselves and such information must be pooled with medical knowledge in the interests of national health. As the White Paper leaves severely alone questions of environmental hygiene and social circumstances as they affect health it does not appear that full use will be made of knowledge acquired in respect of these matters. Generally it may be said that the emphasis of the White Paper is on the hospital service and the treatment of disease and its whole tendency is to make, not only the doctor, but the public hospital-minded rather than health-minded.

Medicine in both its preventive and curative aspects must be practised as a unity and consultants, general practitioners and ancillary workers must have easy approach to one another so that the best can be done for any individual patient and knowledge pooled in the interests of the maintenance and improvement of health. The White Paper gives no indication that it appreciates this essential condition.

Centrally there is no attempt made to centralise in one Government department all the health and medical functions of various Government departments. The industrial medical services of a number of Government departments and the school medical work of the Board of Education remain outside the scope of the jurisdiction of the Minister of Health. The reason given in the White Paper for these exclusions is that these services require experts, but as nearly all the services within the National Health Service similarly require experts, the reason for these exclusions is not obvious.

Similarly, when we consider the local administration of the National Health Service we find that hospital and consultant services are placed under the administration of joint boards of county councils and county borough councils. The general practitioner service is placed under a central medical board under the direction of the Minister of Health. Clinics and child welfare and other services are to be planned by the joint board, but provided and administered by county councils, county borough councils and certain lesser authorities while environmental hygiene and social conditions remain with the existing sanitary authorities. This complicated form of local administration is put forward by the Government on the grounds of urgency. It is, however, difficult to understand this plea because—

(1) there are not sufficient hospitals nor consultants at the present time to give adequate hospital and consultant services;

(2) there are not sufficient general practitioners to give an adequate general practitioner service;

(3) there is not sufficient personnel to man the clinics and other services mentioned in the White Paper.

Those of us who have considered the questions of institutional provision and medical personnel for the service are satisfied that a decade and more must elapse before the necessary provisions are available for the country at large.

It may be taken as an axiom that the simpler the administration the better the administration and the form of administration suggested in the White Paper is not one which will permit the hospitals and consultants, the general practitioner service, the clinics and child welfare and other services to work easily together as a team for national health as the ultimate ideal; nor does the existence of so many authorities permit of the rapid and harmonious development of the service.

HEALTH CENTRES.

Health centres have been freely discussed by the medical profession and the conclusion come to was that there should be a period in which various types of health centres should be tried, *e.g.*, health centres based on voluntary grouping of practitioners or health centres established by local authorities with whole-time or part-time salaried medical officers or other such forms of practice. It was agreed further that all such health centres should be tried out after full discussion between the local authorities and the local medical profession and the results of the experimentation carefully watched. The White Paper, however, proposes in a somewhat airy way that health centres, which are not clearly described, will operate and a Central Medical Board—a Civil Service structure—will have the right to say that a young doctor during his early years shall work in the health centre on a whole-time salaried basis. What is to become of him after this period is not even hinted at in the White Paper.

While I, personally, am in favour of a whole-time salaried service, I am open to be proved wrong. I am therefore in favour of genuine experiments in every type of health centre, but in no circumstances am I in favour of giving any board or individual the right to determine arbitrarily that a medical practitioner shall work on a whole-time salaried basis. If a health centre is established the conditions under which medical practitioners will work in such centres will be laid down, and those who desire to work under these conditions should be at full liberty to make application for appointment to the centre, but should not be compelled to go there at the will of the Civil Service.

As the White Paper asks for constructive criticism I would like to submit for information and discussion what I consider are the necessary foundations for any National Health Service :—

(1) That all the medical functions of Government departments should be brought within one central department with health as its sole function and with a Cabinet Minister as its responsible head.

(2) That new local government areas sufficiently large and with sufficient financial resources to be able to provide the commonly required hospital and health services be devised in which, not only population, but geographical and other considerations are taken into account.

(3) That a National Health Service should include :—

(*a*) hospital, medical, health and ancillary services including environmental and personal health services ;

(*b*) allied and cognate social services ;

(*c*) the encouragement of medical research ;

(*d*) means for the acquisition and dissemination of special knowledge and information for the promotion of health.

(4) That genuine experiments be made as to health centres and the method of staffing by local authorities after consultation with the local medical profession and that the insidious approach to a whole-time salaried service by the arbitrary decisions of a Central Medical Board be disapproved.

(5) That arrangements be made whereby every practitioner, no matter in what capacity he works, shall have before him full information as to all the factors which influence health in order that the service be made a real National Health Service.

The British Dental Students' Convention

(Southern Regional Council)

VISITING students from the Dental Schools of Leeds, Sheffield, Manchester, and Bristol joined with those of the London Dental Hospitals for the second annual convention of the B.D.S.A., which took place in the Physiological Theatre of Guy's Hospital on Friday and Saturday, April 21st and 22nd, 1944.

Mr. R. Drew, chairman of the Southern Regional Council, in opening the convention, referred to last year's pioneer effort, and said that its success fully justified the holding of the present convention.

The following is a brief report of the various items :—

PRACTICE MANAGEMENT.

By Edward Sampson, Esq., L.D.S., F.C.S.

In the Chair : F. N. Doubleday, Esq., M.R.C.S., L.R.C.P., L.D.S.

Mr. Sampson read a paper of such great value to his student audience that it is hoped to publish it in full in a later issue.

FILMS FROM THE EAST GRINSTEAD MAXILLO-FACIAL UNIT.

Presented by C. J. Parfitt, Esq., M.R.C.S., L.R.C.P., L.D.S.

In the Chair : Alan Shefford, Esq., O.B.E., L.D.S.

Mr. Parfitt gave a lucid running commentary to five colour films, showing some aspects of the treatment of maxillo-facial injuries. Films such as these are playing a

very important part in the education of dental surgeons and students in branches of their art for which clinical material is not always available. It is to be hoped that copies of these films made at East Grinstead may soon be incorporated into the curriculum of dental schools.

LEAVES FROM MY NOTEBOOK.

By Prof. R. V. Bradlaw, M.R.C.S., L.R.C.P., L.D.S.

In the Chair: T. W. Widdowson, Esq., L.D.S.

This was a Dental Miscellany ranging from patron saints, through primitive prostheses, to perforated palates—all portrayed by pictures. A unique lecture, which was enjoyed equally by all members of the large audience.

ANÆSTHETICS.

By Prof. R. R. Macintosh, M.A., M.D., F.R.C.S., D.A.

In the Chair: Prof. R. V. Bradlaw, M.R.C.S., L.R.C.P., L.D.S.

Great tribute is due to Air-Commodore Macintosh for covering so much ground in the space of one lecture. He gave a wealth of useful practical hints on dental and general anæsthesia, and on the care of the patient. A large number of slides was shown to illustrate these points. The development of dental anæsthetic apparatus was particularly well described. Further, Prof. Macintosh showed slides and a ciné film of two applications of anæsthesia in research. The first was a series of experiments to determine the actual efficiency of different methods of artificial respiration. The various methods were performed on a volunteer anæsthetised to the stage of respiratory arrest, and the resultant air intake was measured and compared for each method.

The second series was the testing of different types of life-jacket by filming the floating and self-righting positions while being worn in a swimming-bath by a doctor subjected to continuous intra-tracheal anæsthesia.

The convention ended with a very successful dance held on Saturday evening.

Correspondence

MABEL LADY BONSOR MEMORIAL BED.

To the Editor of the Gazette.

SIR,—The members of the Guy's Hospital Ladies' Association are hoping to endow a bed in memory of the late Mabel Lady Bonsor, who was such a true friend to the Hospital.

The Executive Committee feel that there must be many of her friends who would wish to express their regard by contributing to this Fund. They are invited to send a contribution to the Hon. Treasurer, G.H.L.A., Mrs. Sanders, 92, Exeter House, Putney Heath, S.W.15.

I am, etc.,

KITTY G. BULLEID,
Hon. Secretary,
Guy's Hospital Ladies' Assn.

NATIONAL HEALTH SERVICE.

To the Editor of the Gazette.

SIR,—Nobody can possibly object to a desire to improve our National Health Service where it is capable of improvement. Mr. Ian A. H. Munro, however, does not appear to realise that conscription of the whole medical profession is not prompted by altruistic but by purely political motives, and its object is to control the issue of medical certificates by order. Would he also approve of the conscription of, say, lawyers, architects, pharmacists and other professions? Can he imagine the storm which such a proposal would have provoked in any but the medical profession?

Has he any knowledge of what would result from the conversion of the whole profession into Civil Servants whereby they would become the servants of the State instead of their patients? Of the system of confidential reports, snooping and general

interference with individual liberty which would be part of the system ? What is more, has he ever had any experience, as I have, of instructions from higher authority—enthroned in swivel chairs—ordering the employment of proprietary secret remedies of unknown composition, and the banning of expensive pharmaceutical preparations because of the expense ? Does he realise that the cost to each individual is going to be more per annum than the average person ever pays in doctors' bills or N.H.I. ?

I happen to know that in various large municipal authorities arrangements have already been made to increase local rates by two shillings in the pound as a minimal measure to meet the cost, and this is irrespective of the increase in Government taxation and personal contributions, for which latter a sum of five shillings per week has been suggested ?

Finally, to mention the financial aspect, is he aware that with increases of pay in practically every trade and profession—I know of unskilled workers drawing approximately £28 per week who have asked for a " rise " now that income tax is deducted—*the Minister of Health has persistently refused any increase in the N.H. capitation* grant until the recent award of a few pence as a *war bonus* only, and not an increase ? Why was this ? Simply because he knew the fate he intended for the medical profession, whom he already regarded as " in the bag," and considered that any increase would be a mere waste of money. This, notwithstanding the enormous increase in drugs, car licences, petrol, wages, taxes and the general running costs of a practice.

Does he know that the sum of £500 per annum has been suggested as ample income for doctors, with a hint that any increase on the swings will be deducted from the roundabouts, because when they carry on their " practices " in health centres, etc., there will be no need for them to live in anything but small, cheap houses, with no running costs ?

What type of man is going to be attracted to medicine under the new arrangements, and what father would condemn his son to such a future as would depend on a sycophantic attitude to his Civil Service superiors ?

The recent report of the Royal College of Physicians should give Mr. Munro pause. It states that there are " too many students in our medical schools who have neither the character nor the ability to make good doctors." That is precisely the type most acceptable to the new order and best calculated to put up with dictation from their superiors, which is part and parcel of the Civil Service *régime*. Except in war-time in the Services, the man of character and individuality who dares to indulge in original thoughts and ideas is a marked man, if only because he may give rise in the minds of his superiors to the feeling that unless they snub him and keep him down, they themselves will compare unfavourably with him. Never forget the Civil Servants who refused the help which Manson asked to prove his " malaria-mosquito " theory. He was told : " It is ridiculous to suppose that mosquitos can cause malaria. It comes from breathing bad air. That is what the word means, ' mal aria '(' bad air.') "

Whilst giving Mr. Munro full credit for his noble ideals, his views reveal a callowness and inexperience which will certainly be mellowed as he grows older. It is good to start the study of medicine with high ideals, for medicine is a vocation, or, as Jacobson put it, " a holy calling." They should be cherished as something transcendental. The greatest disappointments in a doctor's life come from realising the stark truth that high ideals are not infrequently shattered when they collide with hard facts.

I am, etc.,

" UNCLE HARRY."

Sport

Lawn Tennis Club

At a meeting held on Friday, April 21st, 1944, to elect a captain and secretary for this year, R. G. Lomax and K. Y. Khong were elected the new officers, respectively.

Congratulations to R. Freeman on being elected hon. secretary of United Hospitals Lawn Tennis Club.

Six grass courts are now available at H.O.P., three of which are open for the use of members and their friends every day of the week.

The first trials were held on April 29th ; another will be arranged for the students who started at Guy's on May 1st.

We have an attractive fixture list, including a match against Professor Johnston's VI, we hope. Matches have been arranged for the first and second teams. The number of matches has been limited only by the lack of time and the shortage of tennis balls. Attention of readers is drawn to the fact that the Clubs' Union will be very glad to purchase any tennis balls—old and new.

We played our first match on Saturday, May 6th, against St. Mary's Hospital, one of our strongest opponents. We won comfortably by 5 matches to 1.

Team.—R. G. Lomax (captain) and K. Y. Khong; R. Freeman and G. Wotton; P. Dwyer and E. Filose.

Association

INTER-HOSPITAL CUP COMPETITION.

Winners: Guy's Hospital. Runners up: University College Hospital.

Without playing a match Guy's reached the semi-final, and played St. Bart.'s Hospital at Sidcup on April 22nd. An overwhelming victory was won by 11 goals to nil.

Guy's then met University College Hospital at Richmond on April 29th in the final, which resulted in a win for Guy's by 3 goals to 1.

For the first fifteen minutes Guy's pressed hard and easily thwarted the opening attacks on their goal; the game soon became more open and even. University College Hospital, encouraged from the touch line, opened the scoring from a break through on their right wing. Guy's immediately resumed their attacks and soon drew level, I. A. H. Munro scoring after M. J. L. Sykes had hit the cross-bar. Shortly after Foster scored in the goal mouth through "worrying" the goalkeeper.

The game became fast and furious during the second half and Guy's increased their lead following a break through by I. A. H. Munro.

The team was the same as that which played in the semi-final apart from R. Finney, who ably took the place of A. G. Starte in goal at very short notice.

Team.—R. Finney, N. T. McNeil, F. R. M. Young, S. Stableford, E. G. Murphy, R. D. Rogers (captain), I. A. H. Munro, M. J. L. Sykes, K. W. Foster, A. E. Triste, R. Owen.

This match brought to a close one of the club's most successful seasons, which included the winning of the London University Challenge Cup and the Inter-Hospitals Cup.

In all twenty-six matches were played, of which twenty-three were won, one drawn (Malvern College), and two lost (Cambridge and Norsemen).

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF PHYSICIANS OF LONDON.
M.R.C.P.
April, 1944.
G. T. G. Thomas, M.B.

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
April, 1944.

Surgery.—*F. R. S. Knight, *E. G. Wright.
Pathology, Bacteriology and Forensic Medicine.—E. A. Humphrey, *W. H. Lilly-white.

* Have completed the examination.

Papers by Guy's Men

Bishop, P. M. F., and Another. Implantation of Testosterone in cast pellets. *Lancet*, 1944, i, 434.

Hurst, Sir Arthur. Indigestion and National Health. *Practitioner*, 1944, **152**, 193.

Davies-Colley, R. The Role of Surgery in Dyspepsia of extra-gastric origin. *Ibid.*, 204.

Warner, E. C. The early diagnosis of Carcinoma of the stomach. *Ibid.*, 229.

Shaw, Maurice. Gastritis, *Ibid.*, 238.

Hallam, John W. A Review of Two Hundred and Fifteen fractures of the Maxillæ. *Brit. Dent. J.*, 1944, **76**, 181.

Harkness, A. H. Drug resistance in Gonorrhœa, with special reference to Ætiology and Treatment. *Brit. J. Ven. Dis.*, 1944, **20**, 2.

Johnson, A. G. Sulphamezathine in Gonorrhœa in the Male. *Brit. J. Ven. Dis.*, 1944, **20**, 31.

Lloyd, V. E. Extensive Tertiary Syphilitic Ulceration. *Ibid.*, 42.

Fraulo, J. Anæsthetic Requisites. *Brit. Med. J.*, 1944, ii, 559.

Clarkson, P., and Another. Three cases of Maxillo-facial Wounds. *Brit. Dent. J.*, 1944, **76**, 215.

Mollison, W. M. Discussion on Pain in Laryngology. President's Address. *Proc. Roy. Soc. Med.*, 1944, **37**, 179. (Sect. Laryngol.)

Freebody, D. Some observations on casualties in a Recent Air Raid. *Ibid.*, 230. (Sect. Surg.)

Cohen, Sol M. Amputation under Ice Anæsthesia. (Abridged.) *Ibid.*, 232.

Campbell, A. M. G., and Others. Auricular fibrillation late in the course of Diphtheria. *Brit. Heart J.*, 1943, **5**, 183.

Ogilvie, W. H. War surgery in Africa. *Brit. J. Surg.*, 1944, **31**, 313.

Broster, L. R., and Another. The Adreno-Sympathetic Syndrome with transposition of Viscera. *Ibid.*, 393.

Rogerson, C. H., and Another. Anxiety, Alopecia Areata, Neurofibromatosis, Auricular Fibrillation. *Brit. Med. J.*, 1944, i, 486.

Brock, R. C. The present position of chest surgery. *Brit. Med. Bull.*, 1944, **2**, 33.

——— Bilateral Recurrent Spontaneous Pneumothorax. *Proc. Roy. Soc. Med.*, 1944, **37**, 155. (Clin. Sect.)

——— and Another. (1) Intrathoracic Tumour: For Diagnosis; (2) Bilateral Spontaneous Pneumothorax in an Asthmatic. *Ibid.*, 157.

——— and Marshall, G. Persistent Spontaneous Pneumothorax. *Ibid.*, 158.

——— Tuberculoma of Lung. Removed by Lobectomy. *Ibid.*, 160.

Slesinger, E. G. Acute Peritonitis. *Clin. J.*, 1944, **73**, 46.

Dowling, G. B. Occupational Melanoderma. *Proc. Roy. Soc. Med.*, 1944, **37**, 152 (Sect. Dermatol.).

Forman, L. ? Pemphigus Foliaceus. *Ibid.*, 153.

Barber, Hugh. The modern management of injuries of the Heart. *Med. Pr.*, 1944, **211**, 164.

Kessel, L., and Another. The Parachute Surgical Team. *Lancet*, 1944, i, 381.

Awards

D.S.O.

Lieut.-Col. H. H. Kenshole, R.A.M.C.

Births

DICKSON.—On May 2nd, 1944, at 4, Ormerod Road, Stoke Bishop, Bristol, 9, to Margaret, wife of W. G. Carnegie Dickson, L.D.S., R.C.S.—a daughter.

PRIESTLEY.—On May 9th, 1944, at Worthing, to Mary (née Davies), C.S.M.M.G., wife of D. A. Priestley, L.D.S. (Eng.), 10, Arundel Road, Worthing—a son (Robin).

Deaths

SPONG.—On April 26th, 1944, at Otham, Kent, John Fuller Spong, M.R.C.S., D.P.H., in his eighty-sixth year.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

A FEW weeks ago the British Medical Association produced its first major effort to answer the Government's proposed National Health Service. A questionary was sent to every registered medical practitioner, together with a copy of the White Paper and a criticism of it. Ten days ago the report of the Representative Committee appointed by the B.M.A. to consider the subject was published in the *British Medical Journal*. In that same issue (which members are specially asked to keep) are the answers to questions put by the Committee to the Minister, to clarify the situation a little. It provoked a cartoon in the Press depicting "the siege of Harley Street."

The questionary was drawn up hastily to ascertain the first, and therefore relatively unconsidered, reactions of the profession to the new proposals. As it was framed it deals with major questions and minor clauses with no heed to their relative importance. It was written so that only a letter had to be inserted to register a considered opinion on many far-reaching points. But we worked down the list, painfully trying to be consistent, becoming more and more reckless with those deceitful symbols and ultimately completed it. Then out went the light and one asked oneself, almost in a frenzy: "What do I really want anyway?" Such is, we feel, the benefit of this questionary. The success of rule by vote, otherwise democracy, must ultimately depend on the knowledge and intelligence of the electorate. Here was a vote given before election time, when few had the knowledge to justify reply. For future legislation let little store be set on it, but let that frenzy it awakened one morning, in the small hours, lead to cool deliberation for many days to come.

But, unstimulated, enthusiasm soon wanes; perhaps you may adopt the clichés of the protagonists of the Paper, perhaps those rarer ones of its opponents, or you may just drift. In any case there is little scope for further thought. At other London hospitals the answer has been found by sponsoring debates; well-informed representatives of the B.M.A. and Ministry have opened discussions on the subject—yet Guy's have mustered nothing. An occasional letter to us is all that can be extracted by expressions of the most diverse views in the columns of the *Gazette*. Not many months ago a letter questioned the morality of a dance in honour of the Rugby Club Centenary. Correspondence came literally from the Far East; yet now, when Guy's as a whole may be involved in a change, when its individuality may be lost for ever, when silence is taken as approbation, scarcely a murmur has been heard. Perhaps there is a conviction still in the professional mind that no great change can happen; that bark is worse than bite; perhaps an unfounded confidence that the B.M.A. is more powerful than any Trades Union in existence. So may someone (the onus is on doubtful shoulders) organise something on the line suggested to relieve this unsatisfactory situation?

THE obituary published recently of Mabel Lady Bonsor, would not be complete without quoting the tribute received from our president, Lord Goschen. He writes:—

> "My Dear Miss MacManus,—Would you very kindly represent me at the memorial service to Lady Bonsor on Friday in the Chapel? I am not able to come to London and would like to pay my tribute to her memory. She was a valuable and kind friend to Guy's. . . ."

WE wish to congratulate Mr. Blaikley on his election to the Fellowship of the Royal College of Obstetricians and Gynæcologists. This is an honour received by few so early in their career, and justly indicates that he is as highly esteemed in outside practice as he is in the Hospital.

THERE was a time when the wit of certain physicians was proverbial—when at lunch a ward clerk would dissolve into fits of laughter as he divulged " X——'s latest." Well, we still hear the laughter, but happen not to hear the " crack." Some we have heard are worthy of a wider audience yet by themselves are not sufficient to include in the *Gazette*. But we are hoping people may let us know of the more choice remarks that all may hear.

Obituary

THOMAS REGINALD HARVEY, M.R.C.S., L.R.C.P.

THOMAS REGINALD HARVEY, aged sixty-two, of 2, Park Road, Purbrook, Hants, died at Guy's Hospital on Wednesday, May 10th, 1944, after a long illness borne with patient fortitude. He was the younger son of the late Fleet-Surgeon Christopher Harvey, R.N., and Mrs. Harvey, of New Eltham, Kent; was educated at the Royal Naval School at Eltham, and afterwards at Hurstpierpoint College, Sussex. He was trained for the medical profession at Guy's Hospital, taking the degree of M.R.C.S., L.R.C.P. 1909, and was Clinical Assistant to the late Sir Alfred Fripp. He practised, first, for five years at Avebury, Wiltshire; twenty years at Rickmansworth, Herts; and came to Purbrook, Hants, four years ago. In his younger days he was an enthusiastic cricketer, captain of Guy's Second XI (1905), and of various clubs afterwards; he was also a keen Rugger player, playing for Guy's as three-quarter in pre-Cup-tie trials.

The funeral was held in the Hospital Chapel on Tuesday, May 16th, conducted by the Chaplain, the Rev. V. McClaughry, and afterwards at Streathan Park Crematorium.

K. S. H.

SURG.-LIEUT. MYLES C. CROSS, R.N.V.R.

MYLES CROSS was posted missing, believed killed, as a result of enemy action on December 31st, 1943. The news of his death has been received at Guy's with deep regret, for he was popular in all spheres of Hospital activity during the years that we had known him.

Myles was born in 1917 and was educated at Lancing and at Trinity College, Cambridge. With several of his friends he came to Guy's in October, 1938, and soon developed a deep attachment for the Hospital and its traditions. His interests were wide and, apart from his love of medicine, he gave loyal support to many of the activities of the Clubs' Union. He was conscientious and reliable in his work and his whole-hearted enthusiasm in whatever he did is reflected in an exceptional Hospital record. His pleasant and unassuming manner won for him the affection of many friends, and from the early days he always had the confidence of his colleagues and his patients. At the commencement of the War he was posted to several of the Sector hospitals, but during the London " blitz " he spent much time at Guy's assisting in the treatment of air-raid casualties and in the protection of the hospital. His comradeship and untiring efforts in those long days and nights were an example to many. He believed in a purpose beyond the chaos that surrounded us and his influence on his friends was considerable; many of us feel very conscious of the privilege of having known and worked with him.

He obtained a certificate for the Golding Bird Prize in obstetrics and qualified M.R.C.S., L.R.C.P. in 1941; he was then appointed Casualty Officer and, later, House Surgeon at Guy's Hospital. After these two periods at Guy's he was posted to Orpington Hospital, where he held the appointment of House Surgeon for a further three months. In 1942 he completed his Cambridge M.B., B.Ch. examination and became engaged before being released from the Sector for military service.

Myles had always been attracted to the sea, and he was proud of being accepted for service in the R.N.V.R. in September, 1942. He was appointed to H.M.S. *Clacton* and, shortly afterwards, sailed for duties in the Mediterranean area; in this ship he saw service in the North Africa landings, at Pantellaria, Sicily and Salerno. In all his letters he maintained that cheerfulness and faith in all things that matter, which endeared him to his friends and makes his memory one that will be honoured and respected so long as his friends remain.

D. E.

The Real Tuberculosis Problem

By J. B. McDOUGALL C.B.E. M.D., F.R.C.P. (Ed.), F.R.S.E.,
Medical Director, Preston Hall, Maidstone, Kent.

THE reason why there are so many deaths from pulmonary tuberculosis is because it is an infectious disease, which is, to a large extent, uncontrollable. True there is a section (172) in the Public Health Act, 1936, which provides for the removal of infectious cases of tuberculosis to hospitals. Local authorities may apply to the Court of Summary Jurisdiction for an order for removal under certain conditions, most of which defeat the very objects of segregation. The number of instances in which advantage has been taken of the Act could be counted on the fingers of both hands. The plain fact is that there is not yet in this country a fear of tuberculosis analogous to the fear of leprosy, and the public will only agree to pay for, accept and submit to a policy which they feel is an investment against their own conception of the dread of a particular disease. None who are alive to-day will ever witness the compulsory segregation of the open case of tuberculosis, even if the arguments in favour of such a drastic procedure were ever likely to be generally accepted by the population as a whole.

Just what is the magnitude in terms of individual patients of this problem which I have suggested is, to a large extent, uncontrollable ? On statistical analysis we are on firmer ground, for we have the official returns of local authorities to the Ministry of Health which give a reasonably accurate guide to the position from year to year. Some twenty-five years ago there were nearly 34,000 deaths per annum from pulmonary tuberculosis ; for the year 1938—the last available returns—the annual deaths had dropped to about 21,000. We know also that on any given day there are about 68,000 open cases of pulmonary tuberculosis in England and Wales—that is, infectious cases of the disease. All of these are not, of course, equally infectious ; some 11,000 are in sanatoria or hospitals, leaving, therefore, about 57,000 free to spread infection amongst the general population to a greater or lesser degree. The majority of deaths in any year are in patients who were included in the sputum positive group of the year before, and the majority of new open cases in any year are recruited from the negative cases of the previous year. Lastly, the dispensary registers show that newly diagnosed cases come along at about the same rate—*i.e.*, approximately 20,000 per annum. There is, therefore, a cycle which statistical evidence proves to be remarkably constant from year to year, though the tendency has been for the number of deaths to fall and for the number of open cases detected to diminish with the passing of years. It is certainly true that the actual incidence of deaths, the prevalence of open cases and of non-positive cases are higher than the figures just given, because these figures refer only to tuberculosis dispensary records and not to the incidence in the population as a whole. Many open cases are probably never notified at all and it is common knowledge that hundreds of patients with pulmonary lesions due to tuberculosis are never diagnosed at all. Initial experience in mass radiology tends to show that pulmonary lesions may be present in about 1 per cent. of the adult population of this country. Nothing, therefore, is more certain than that there are many more cases of pulmonary tuberculosis in the country than we know of at present. It is too early yet to arrive at a figure which is likely to be generally accepted, but with the accumulation of results from mass radiological surveys some interesting data will soon be available and will, I am convinced, drive home to the public generally the fact that the disease is much more prevalent than our present statistical records would lead us to believe. Up to the present, intensive radiological surveys have been conducted amongst some of the healthiest cross-sections of the population—members of the Service departments, in schools and college undergraduates. If similar surveys were to be made in certain selected groups the result would no doubt be very different. In 1933 H. R. Edwards inaugurated a survey of some 225,000 persons in the City of New York and found clinically significant tuberculosis in 2.5 per cent. of the total numbers X-rayed. Altogether 162,446 radiograms were taken. The lowest incidence of chronic tuberculosis was found in college students ; it was amongst homeless, unsettled males that the incidence is highest. An important conclusion from this survey was that no fewer than 16 per cent. of the homeless adult males examined were found to be suffering from definite pulmonary lesions. That " nests " of tuberculosis do exist is well known and has been emphasised by Hutchinson, Lyle Cummins and others in Wales. The late Dr. D. A. Powell has justly remarked : " We hardly know a tithe of the cases of

tuberculosis which occur in our midst and we are far from having official knowledge of all cases of even frank clinical disease that are clamouring for recognition."

When I said at the outset that this disease was, to a large extent, uncontrollable I had, of course, in mind our comparative lack of knowledge as to the true incidence of infection in the community as a whole. It is not an easy task to ferret out all open cases of tuberculosis. Mass radiology is a contribution, no doubt, but our goal will never be attained by confining this method to the presumably healthier groups of the population. To catch fish it is wise to go to the best river. When Dr. Godfrey, Junior, the State Commissioner of Health for New York, invented the descriptive term "shoe leather" epidemiology he had in mind that form of investigation which necessitates workers going out "on the highways, byways and alleys, walking the streets and climbing the stairs, or hiking over the roads to seek out sources of tuberculous infection."

It is scarcely within the bounds of possibility that preventive medicine will ever eliminate tuberculous pathology from the human lung, but it is certainly not outside the sphere of practical accomplishment to reduce the "national dosage," so to speak, of tuberculous infection to a point which will limit the number of open cases in the country and thereby lead automatically to a reduction in the morbidity and mortality rates. I believe the real problem in tuberculosis revolves round the open case. Existing cases must be speedily discovered and adequately treated with the magnificent dual object in view :—

(*a*) The lengthening of the life of the unfortunate patient by appropriate treatment, residential if possible ; and

(*b*) The prevention of massive infection throughout the country.

Methods for the discovery of the open case have already been touched upon. True as it may be that many a person in these "highways and alleys" is suffering from definite tuberculosis masquerading under the guise of bronchitis, recurrent colds and even asthma, it is clear that the majority of new open cases come from that group which have still a closed lesion. The negative case of to-day is all too frequently the open case of to-morrow. It is the general recognition of this fact that compels physicians to advise patients with demonstrable tuberculous lesions to seek treatment at the earliest possible moment whilst the disease is still in its early stage. These negative cases must be prevented at all costs from becoming open cases, for that significant change, however trivial its pathology may appear on an X-ray film, is the pointer to graver potential dangers ahead. Therefore, examine negative cases frequently, check up on their radiological appearances, scrutinise them for signs of activity until there is reasonable proof that the lesion is indeed quiescent, dormant and still. Guard the case of simple pleurisy with effusion against the optimism which may follow absorption of fluid ; make sure that the effects of infection have not intruded themselves into the pulmonary tissue. There is indeed no field in the whole realm of medicine in which the physician can be of greater value to public health than in his treatment of the negative case of pulmonary tuberculosis.

But what of the open case where the dice is so heavily loaded against both the patient and the doctor ? It is here that more active treatment becomes essential. The way is now open for clinical action of many kinds and descriptions. The very first duty of every physician who is confronted with the open case of pulmonary tuberculosis is to pursue that line of attack which will convert the sputum, if at all possible, to the negative state. In a brief note of this kind it is impossible to deal with the various types of cases encountered clinically, with the various forms of collapse therapy which may be advised, with the differences between exudative and productive lesions in different age groups and so on. In general terms it may be stated that the sooner the open case is detected the more amenable is it likely to be for one or other kind of collapse therapy. But there is no excuse whatever for leaving the open case merely under observation, fulfilling his employment and living in what may be unsatisfactory domestic surroundings—merely hoping for the best. Conservative treatment in an institution may produce the desired result it is true, but treatment of some kind is always necessary. Students are familiar with the excellent results which so often attend a successful artificial pneumothorax or one of the plastic operations, and there are not many fields in medicine in which the trained physician and surgeon can work to greater advantage in consultation. Residence in an institution is preferable for the majority of these cases, especially during the period of investigation and active treatment, for the estimation of the physical capacity of the patient to undertake exercise in any form when the more active measures have been completed, can only be con-

ducted adequately under medical supervision. For the so-called middle-stage group of patients—those who have gone undetected for some years and who have fought many past battles with the tubercle bacilli, not all of which have been lost, and who are the heroes of many fights—there may still be a surgical procedure to save them from drifting into the advanced irreparable class. There are good and bad chronics, but even the worst should have his claims weighed carefully in the clinical balance before deciding that his fate must be left to the mysterious and uncertain laws of pulmonary fibrosis. Many, unfortunately, must necessarily come to sanatoria and hospitals where, let it be said, they may live for years leading a sheltered life under constant medical supervision. The middle-stage chronic under such conditions may surprise the most experienced of us in expectation of life. At Preston Hall my experience has taught me never to give a prognosis as to the immediate future of any middle-stage case which has the patience and perseverance to lead a mode of life which we know to be within his physical resources. A considerable number can, when facilities are available, earn a livelihood in part-time employment; that is to say, they can be rehabilitated "relatively." One has seen the so-called "hopeless chronic" in a village settlement laugh at the one time early case, who two or three years previously left the institution with "nothing much the matter," and welcome him back into the well-established group of chronic open cases. The longer we can keep the open case under institutional treatment the better both for himself and for the population as a whole. One has little time or patience with those who say that there may be some risk of "detuberculinising" the general population by the removal of open cases from their midst. Therein lies medical folly, for there are more sources of infection than the open chronic case; there are even more open chronic cases than we know of. There is, indeed, little likelihood of obliterating the virulence of the tubercle bacillus by the expediency of voluntary segregation of the known open case, for opportunities for infection will still exist, despite our best endeavours.

The real problem in tuberculosis prevention can therefore be reduced into the double harness of treatment and prevention. It is impossible to conceive success from any attack which is unilateral. The tuberculosis physician becomes inevitably an adjunct to the public health service of the country from the very moment he diagnoses the case as one of pulmonary tuberculosis; the public health administrator cannot contribute adequately to the solution of the problem unless he appreciates the fact that the physician is the agent who can, by appropriate methods of treatment, contribute to the diminution of massive infection in the population as a whole, which is, after all the most valuable service to the public health.

For Practices That Yet May Be

By EDWARD SAMSON, L.D.S., F.C.S.

THIS would seem to be a most inappropriate time to address you on the subject of practice management—a time when the future of dentistry, like that of medicine, is somewhat confused, and its entire structure likely to be drastically reformed, if not changed beyond recognition. Most people to-day appear to be obsessed with the belief that everything everywhere must be changed, and just as long as change is wrought it is *ipso facto* for the better; and it so happens that dentistry is to be one of the first phases of national life to undergo the magical transformation from being a normal profession to becoming a part of the grave new world to come. As the clouds of peace begin to gather, the future of dentistry grows ever more uncertain. One thing, however, is fairly clear—dentistry, or the greater part of it, is likely to come under entirely new management—that of the State. Yet since the subject of practice management was your own choice, I can only imagine that dental students are such buoyant optimists, or die-hard conservatives, that they are convinced that there will remain private practices to be managed.

In my student days we made every endeavour to eliminate any subject which, in our wise judgment, we imagined of no use to our future work. This included most of the curriculum. If students have not changed since then it is to be assumed that a few of you at least believe that a knowledge of dental economics will be of use to you in the glowing Utopia to come, where the State will provide for all—though who will provide for the State we are not told. With that view I entirely agree. Indeed, if I imagined that the agitators who are so anxious to hand the freedom of dentistry to

bureaucratic control were going to have their absolute way, I would not now waste your time or mine explaining methods of conducting hypothetical practices. How much of private practice will be left for the individualists to enjoy will depend, not upon the planners, but upon the numbers of you students who are determined to retain your individuality. I am hopeful, too, that many of you gentlemen are strong individualists who do not intend to submerge your freedom and way of life in a vast impersonal machine, nor that you will readily be tempted to sell your liberty for a safe income, the protection of a Government department and the distant prospect of a pension.

Safety and protection by the State do not provide the essence of success, neither is the prospect of so sheltered an existence an attraction to young men with a keen sense of ambition. For ambition is not so disreputable a possession as many now attempt to make it appear. Due to a great deal of muddle-headed philosophy and wrong-thinking ambition, private enterprise and that queer sin, the profit motive, are lumped together as things to be shunned in the better world of the future.

Without indulging now in arguments on sociology or reform I must say I find the greatest difficulty in believing that the squirrel that puts by his nuts for the winter is sinfully activated by a profit motive, nor can I find any one aspect of life where man or animal does not create some surplus for his security and comfort. Even in the economy of the body a reserve must be maintained ; and what is profit but an accumulated reserve ? That being so—there can be no more glory or altruism in deriving one's reserve, or profit, in the form of a pension from the Government rather than from the effort of private practice. Frankly, I give greater credit to the private practitioner who faces the risks and responsibility inherent in his type of life, knowing that he will succeed or fail by his own efforts.

The dental profession owes its progress, scientific and political, to outstanding individualists who worked alone, unaided by Government support, achieving their success, sometimes in face of heavy opposition—men like Miller, Tomes and Mummery. It is hard to imagine that characters of that type could be tempered in the tepid fires of a Civil Service department. It is private practice with its hazards, its disappointments and its stimulus to personal endeavour that breeds the qualities upon which dentistry will thrive as a respected and independent profession. Therefore, I hope I am addressing men who are not afraid to embark upon such an adventure. It is with that conviction that I offer my few suggestions for making the way somewhat easier, though no less individualistic.

Moreover, quite apart from the designs of the reformers or the intentions of newly qualified students, there is a quality of independence in the British character that resists widespread control and which will not readily submit to losing that intimacy and confidence which exists between practitioner and patient—which, in fact, are the firm basis upon which well-established private practice stands.

It has been estimated by those who use statistics as a polite form of lying, that about 10 per cent. of the population will be available to private practice after the Ministries have finished handing over the rest of the population to the regimented dentists. If these are reliable figures—and they, no doubt, are as reasonable as any statistics—it is this 10 per cent. of people for whom the proper conduct of well-organised practice will be needed—for they will provide the type known as the private patient. And a most determined type it is. First, she claims special rights and privileges for the fee she pays (they are always shes)—the right to hæmorrhage from a socket at midnight—the right to discover that a three weeks'-old toothache becomes unbearable on Sunday—the right to break her denture when the mechanic is on holiday —the right to waste twenty minutes of a half-hour appointment explaining why the cook left—the right, in fact, of possessing her own dentist, body and soul, on all occasions, mostly the inconvenient ones. These, among many others, are the privileges claimed, as though by divine right, by the patient who chooses her own dentist ; the times she will visit him and the fees she will pay, or promise to pay—privileges she is not lightly going to hand over to a Central Dental Board or a local health centre.

Please do not imagine, however, that you will be praised for your skill and knowledge, or that your practice will flourish beyond all expectation because you are a prize-winner in dental anatomy. It is a regrettable fact that your good name may often rest upon a number of trifling factors, entirely unassociated with your essential ability as a dentist. First among these is that you do not cause pain—especially when filling teeth. The number of men who have gloried in the reputation of being clever dentists because they inflict no suffering must be legion ; the same number, I trust,

have always removed all caries. I am excepting the use of local anæsthetics. Of course, the fillings should not fall out too soon after insertion; but, above all, your practice will expand when you are regarded as a kind, gentle man. Then there will be your personal charm, your courteousness, your sympathy and understanding. Even the perfume of your soap, or the way you wash your hands, may be of greater importance to your public than the way you apply a rubber-dam or don't. It is these intimate details upon which many patients place so much importance, and by which practices often live or die. Indeed, it is a shocking indictment of general ignorance that the more accurate forms of treatment are usually the most disliked. You will not be thanked for fixing a matrix band well and truly under the gingival margin. You will be positively loathed if you keep the mouth open for long periods while you insert a filling carefully into an aseptic cavity. While the danger to your reputation of taking plaster impressions that smear lipstick and prove the impermanence of permanent waves is quite disastrous. Thus you will discover early in your careers that discretion is the better part of practice, though it is happily possible, with just the right amount of care, to apply the highest principles of our teaching with the minimum distaste to the patient. Patients can be educated to realise that there is more to dentistry than filling a tooth or removing it—and I believe that solid, lasting practices grow in proportion to the time their owners devote to this chair-side propaganda, for though the public may be an ass, it is willing to become an educated ass. In this context the consultation, which I will discuss later, is invaluable.

My own experience has been that patients can be easily interested in their mouths, and as that interest is stimulated and grows, so they become a more firmly established part of the most lasting and ideal of all practices—the family practice. If people know what is to be done to their mouths, why it is done—and can understand the intelligent reason for it—as long as there is one—they will readily co-operate, and ceasing to be an endless stream of reluctantly opened mouths—they are made willing partners to a rationally designed plan of treatment. To this end the study model is indispensable, of which I hope to explain more later. Here I would only emphasise that the best results, economic or scientific—can only be produced where the dentist encourages the patient to use her brain as well as her mouth; sometimes the most difficult of all his tasks. And what are the economic possibilities to be expected from these efforts ?

Before the war it was said, with some authority, that the average practice earned the surprisingly low figure of £400 per annum gross. This may appear a poor prospect, yet it is not an impossible estimate taking the country as a whole. Against that, at the other extreme, I have in my possession the ledger of a man who was brave enough, or fool enough, to charge seven guineas an hour for his time. No account he rendered was for less than six guineas; most amounted to fifty or sixty, while one patient paid him eleven hundred pounds in a single year. What is commonly called a good patient ! Needless to say, that was in the distant boom days of 1925, and obviously he had very few patients upon his books, for there are few who are prepared to meet dental expenses in that proportion. His was a case of the higher the fewer—the higher the fees the fewer the patients. Neither is his an example I would suggest following, for, apart from the insecurity of such luxurious standards, a dentist must possess certain remarkable ways to command fees of that type. Between this extreme instance and the estimated average of £400 a year, I am certain there is, and will be for years to come an average stratum where comfortable livings may be earned by any man prepared to put as much into dentistry as he hopes to get out of it.

While there is no simple formula by which success may be achieved, there are certain methodical plans upon which practice organisation ought to be based in order to lighten the dentist's task, and by which he may expect to receive the maximum return for his endeavours. It is these primary principles which I intend to offer you now. But first let me disabuse your minds on one point. It is often imagined that dental economists possess a magical secret whereby indifferent dentists may learn how to amass fortunes at the same rate as bookmakers, though with more dignity; or that they can produce easy systems for building practices composed entirely of the wealthy peerage. All that dental economics offer is to fill the grave omission in the student's education which leaves him, on qualification, entirely ignorant of how best to apply his knowledge to the most remunerative ends.

Time is the ruling factor of every dentist's life, and it is not too dogmatic to state the axiom that he will prosper in direct proportion to the wise employment of his every minute. If he is giving the best of his skill to the greatest number of people in the

shortest possible time, the more people he will be benefiting and the larger his practice will grow. The more patients he can see in every day, week or year, the more he and they will derive from dentistry. To achieve this end the dentist cannot increase his number of hands nor expand time, though efficient organisation may turn time into an asset instead of a liability. Instead of working against time, he must learn to work with it. However empty his appointment book he ought always to be at his practice during those hours he has decided to work. If nine until six o'clock are his times, he must always be available then. Nothing is so disturbing as for patients to call or telephone only to be told that the dentist is not in. Besides which, there are many ways of rendering time productive beyond using it for operative work. The examination of records, ledgers and progress graphs is time well spent, while even the occasional reading of a dental journal or text-book will prove a fruitful if rare experience.

At present there are a number of schemes being published which claim to save time and energy in dental practice. Perhaps the best known and most discussed is the proposal to employ dental hygienists—half-trained ladies who will scale teeth, execute single fillings and treat deciduous teeth with the object of leaving the dentist free to perform what are supposed to be the more important operations. This is not the time to discuss such controversial views, though it should be remembered, in relation to intelligent practice management, that there is no such thing as a simple operation. The successful dentist will regard every form of treatment as demanding his utmost skill and application, neither is it reasonable to think that so personal an organisation as a dental practice will best succeed when part of its work is delegated to assistants. The patient expects to be treated by the man whose name is on the brass plate, and only the utmost tact will succeed in diverting her to assistants or partners, let alone a chorus of amateur scalers.

Another delightful proposal is to hand over all prosthetic work to mechanics, thereby relieving the highly trained dentist of what some regard as the less dignified aspect of his work—and, incidentally, the most remunerative. Thus we have so far saved him the labour of scaling, gum treatment, extracting and filling deciduous teeth. Finally, there emerges from America the ingenious device of turning out all conservative work on a belt system. This visualises a series of surgeries in which the first operator prepares cavities, passes on the patient to the next operator who medicates them, and finally to the gentleman who fills them. What will be left to the owner of the practice for his amusement is difficult to see, unless he is to spend his greatly increased leisure in brushing up his bacteriology, or occasionally attending the fractured jaws occasioned by some of his half-trained staff. As far as dental economics are concerned the ideal practice is the one in which the dentist performs all operations with enthusiasm while carefully co-ordinating them into an intelligent whole. I do not believe that time is ultimately saved, and certainly not expense, by delegating work to numerous sub-specialists of what is already a specialty. The practice is the man who conducts it, and to him his patients come for help and advice.

First and foremost and, above everything, I place the possession of a second surgery as invaluable to time-saving. The dentist should learn early to work in two surgeries—if not simultaneously—almost so. In the extra room innumerable hours may be saved and utilised to advantage. There all extractions can be done, leaving the patient to rest at leisure after the operation, attended by the nurse, while actual time employed by the dentist will be only a few minutes. If extractions are carried out in the one and only surgery, either the patient must be hurried away or valuable time is lost. In the second surgery the casual patient can be interviewed for a few minutes ; there a denture may be eased, a dressing inserted in a painful tooth, a few minutes' consultation allowed, and a variety of other matters attended to while the first surgery is still occupied. Time is wasted or misspent all day by the dentist who is confined to one working room. While a porcelain filling is setting ; while elderly ladies are removing layers of coats, ornaments and spectacles ; while younger ones are replacing lost lipstick, the operator is not required and is more usefully employed in his second room. The nurse can well attend to these non-dental performances, arrange further appointments and clear instruments away, leaving the dentist free for more remunerative occupation. In the baldest terms, the earning capacity of the extra room cannot be overestimated ; nor is it to be compared with dental hygienists or belt-produced fillings as an asset.

Students, long accustomed to strolling out for a cup of coffee while plaster impressions set, will easily adapt themselves to using an extra surgery. It is merely a matter of strolling in a different direction for a different purpose. Before expending money on elaborate equipment, the fitting up of an auxiliary surgery should take precedence. From my own experience I would estimate that I add one to two hours extra work

every day by the use of my second room. In terms of time, fees or patients that produces a vast total in the course of a year.

In this context it is well to emphasise again that the most solid, lasting and successful practices are the family ones, in which the young children are treated and grow up to be confident and faithful patients. Where a child is happy with its dentist the entire family will usually be satisfied—which, incidentally, is another argument against the hygienist. In order to accustom the small or nervous child to the atmosphere of the surgery, it is an admirable scheme to let it spend a little while in the second surgery with the nurse. Here it will become familiar with the chair and equipment and lose its fear, while no time is wasted by the dentist. Furthermore, many subsequent hours will be saved by having a child to treat that is already free of apprehension. Of course, the presence of the nurse is essential on these occasions if damage to equipment is not to outweigh the time saved. Intelligent children are a danger to delicate apparatus.

If there is the slightest doubt about the child's confidence in me or its coming treatment I always spend one—perhaps two—visits allowing it to become fully accustomed to my surgery. Thus, having lost its terror of all the strange surroundings, ever after there is little or no difficulty in proceeding on normal lines.

Further to the question of time in relation to proper practice management is the workshop. A dentist without his own workshop is like a man without a wife; he never knows where he is. There has been of late years a growing tendency to send prosthetic work to mechanics to the profession. Excellent as many of these are, the time lost and the disorganisation caused by employing them for a busy practice is enormous. Every small adjustment to a denture must be sent away or done by the dentist himself with subsequent time wastage. Every urgent repair necessitates a telephone call and elaborate arrangements. And that is why repair shops flourish—because they claim to execute their work with speed.

Even the most expeditious prosthetic establishments cannot adjust their programmes to suit all their clients, and it is thus that the hard-worked dentist suffers most. Without one's own workshop it is often impossible to undertake hurried work or elaborate constructions easily, since the mechanic to the profession must serve many masters—but the dentist who controls his own can re-arrange his time-table to suit himself or the patient. Most important of all, it is quite impossible to supervise prosthetic work, as it should be supervised by a capable operator, when it is being carried out some miles from the practice, with the result that it must be left largely to the discretion of the mechanic—a most unsuitable arrangement, since he seldom sees the mouth he is working for. Economically also the system of sending out prosthetic work is unsound, if for no other reason than that the mechanic to the profession has to make his profit over and above that of the dentist.

Now, it so happens that I am strongly opposed to the undue importance prosthetic dentistry has assumed in every-day practice. This branch of our work has unhappily become grossly commercialised by a few who have exploited the ease with which profits can be made from it, degenerating into a process of manufacturing and selling the greatest number of dentures in the quickest time. Indeed, much of our practice may now be divided into factory and satisfactory methods. And since this aspect of dentistry is the only one in which we directly exploit labour for profit it is the most lucrative—a fact which has been readily seized upon by our less ethical colleagues. Indeed, there are some practices in the country where there is no engine, the sole equipment being forceps, trays and composition with a workshop—a very busy workshop, humming with activity as vigorous as that of a car factory. Nevertheless, while we still undertake denture-making and it is possible to approach prosthesis as ethically as the operation for removing an odontome; since we will continue to be prosthetists, it must honestly be admitted that the workshop is where our greatest return is made. Dentures demand the least of a dentist's time and most of his hired man's; thus they carry the highest reward. This being admitted, the most efficient method of using that time is for the dentist to control his own mechanic on his own premises. Nor is there any difficulty in the way of earning a fair fee from denture-making in a highly ethical and just manner, as long as the dentist is absolute master of the work being produced. In that way he is in a position to remove the commercialism which invests a great deal of denture production if he wishes.

Probably the most neglected procedure in dental practice is the consultation, if for no other reason than that dentists have stressed it too little, until it has become almost entirely absent from our daily work. Not until the last three months have the

Approved Societies agreed to pay the handsome sum of five shillings for a consultation as long as it is claimed only once a year for each patient. Dentists themselves seldom ask a fee for their advice, which may be explained by the fact that they do not think it justifies one. Certainly few practitioners provide anything which, by virtue of atmosphere or manner could be graced with the name of consultation. It is therefore little wonder that patients who place some value upon dental skill have less or no respect for dental advice. Nevertheless, the dental consultation may as easily be elevated to a dignified level as that of any other specialist branch of medicine, with great benefit to both dentist and patient.

Firstly, where possible, every new patient should receive a consultation in a consulting-room, where the white coat and chromium fittings are conspicuously absent. There is no ease or reason in immediately ushering a patient into the chair. The surgeon does not consult on the operating table. Further, the patient, because he is in the chair expects treatment to begin as soon as possible. Thus the patient is at a disadvantage sitting with a strong light in his eyes, a dentist bending over him, and a massive array of instruments (painted in whatever seductive art shades). If a patient is expected to be at ease, give information with confidence, and come to decisions she will not regret later, sitting in the dental chair in the shadow of the dental unit is certainly not the ideal place.

The wishes and condition of the patient can and ought first to be discussed in a consulting-room ; this being absent, at least in an ordinary chair at a desk side, both patient and dentist being seated. This is not a poor imitation of the consultant, but a good elevation of the dental consultation to its proper place. Previously it has largely been regarded as a waste of time. The public consults consultants ; visits doctors ; but pops into the dentist for him to have a look round, much as it asks the man to come and inspect the gas fires. Only a correctly conducted consultation in the right atmosphere can bring dental knowledge and advice into the same prominence as operative work. This occasion should be devoted entirely to the type of discussion that is usually pushed in between a couple of fillings or indulged in by the dentist while the patient has a saliva ejector in her mouth. Effective, no doubt, but somewhat one-sided and hardly likely to encourage in the patient an unprejudiced view.

Again, except for the reason that the white coat suggests asepsis, despite the fact that it is neither sterile nor ever worn for less than three days at a time, I mourn the passing of the old frock coat. At least it did not pretend to be more than the uniform of a professional adviser ; the white coat is a pretentious imitation of the surgical gown, in which we consult, operate, smoke or even take a bite—in the alimentary sense. Certainly this hybrid garment is unnecessary where a consultation is to take place in a consulting-room.

At this first visit all essential information should be obtained—dental history, general history—indeed everything essential to subsequent treatment. Fees, radiographs, study models can all be usefully investigated at this time, when nothing more need be done to the mouth than a careful and accurate examination. Also, the models or diagrams ought to be explained to the patient in order to gain her co-operation in after-treatment and, most important, that she may gain some conception of what is planned for her mouth. If the patient is unable to make an intelligent grasp of what is being explained—which is often the case—she will probably have just enough sense to observe that, anyhow, the dentist is reasonably intelligent. A great help for future occasions this preliminary introduction of the patient to her dentist, and acquainting her with the principles of dental treatment, are essential features of proper practice. Until the dental practitioner presents his knowledge with the same deliberate care as he endeavours to execute his operations, the public will place no store upon that knowledge—indeed, cannot know of its existence. Moreover, while dentists give their advice in hurried minutes during treatment, they themselves gradually grow to place all the emphasis upon their craft and disgracefully little upon their knowledge.

The man to whom his patients come seeking advice will possess a solid, lasting practice, for he receives the greatest of all respect—a respect for his intellect. That is why I trust that many of you will decide to embark in private practice where alone the consultation can be given in the intimacy and confidence it deserves. Thus in time we may steer a steady course between the dentist and his half-crown extractions on the one hand, and dental surgeries and thirty-guinea gold dentures on the other.

(To be continued.)

Guy's Letter

TO suggest that summer has come is a hackeyed and, at the moment, somewhat cynical manner in which to start this letter. But come it has—that is, if we are to believe the calendar and rely on our surreptitious, but none the less acute, observations on the minor seasonal changes which occur in the uniforms of the nursing staff. And with the change of season have come further alterations among our briefly flowering residents. Arthur Williams, to our regret, has been uprooted and has left us, and so has D. E. M. Brown. In their places we are pleased to welcome P. L. Brangwin and M. J. Cutler. Some months ago now Drs. French and Tillman departed to join the Army, and in their places have come Drs. Southwell and G. Thomas as Medical Registrars.

A large-scale invasion of our territory was carried out on May 1st by the first- and second-year students. The sight of so many of these bronzed young men from the country flocking, with light and easy steps, through the Colonnade as we stagger, somewhat blindly and hurriedly, to our last-minute breakfasts is a rude shock to our wearied and weakened constitutions. However, we are very glad to see them except at meal-times, where, in the restaurant (housed once more in the bomb-battered college) there is mutual enmity as we rush over from Nuffield House to join the fight for seats to get something to eat.

York Clinic is now open for the pupose for which it was designed, if we are to believe the night staff of the Hospital. Apart from this, however, organised entertainment in this area has been at a minimum lately, to the disappointment of those who, for five long weary months, have been patiently awaiting the day when the Zamba should first be performed inside the Hospital. In fact, things have been so quiet for so long now that we have nearly all forgotten how to do the Conga, to say nothing of the more orthodox dances.

Now, like everyone else, we are awaiting with mixed feelings the onset of the Second Front. And, compared with the news that already comes from the world's battlefields, our little gossip seems so insignificant that we feel we would do well to leave you here, until next time.

J. K. M.

Correspondence

NATIONAL HEALTH SERVICE.

To the Editor of the GAZETTE.

SIR,—I did not like the letter you published last week from your correspondent, "Uncle Harry." I did not admire his wildly destructive criticism nor his ill-concealed slur on Mr. Munro, contained in his seventh paragraph; nor do I like the way all this is issued from under cover of the benevolent pseudonym "Uncle Harry." If he wishes to take a stand on the issue of the National Health Service, let him publish his name and his connections with this Hospital (other than writing to the *Gazette*), that we may be helped to judge the worth of his opinions.

His letter is a list of exceptions, minor abuses, hearsay and imputations. The minor abuses which he has met have their counterparts in every system, and must be fought wherever they are found. His other statements are useless as evidence, as he forgot that in making them, he bore the onus of proving them.

He has completely missed the point. The point, surely, is that modern medical methods have advanced very far, and that such ill-health as remains in this country is largely a failure of application of our knowledge or a failure of prevention of ill-health. If the White Paper meant no more than a *free* and *complete* medical service for everyone, it would be so great an advance in the application of medicine as completely to discredit your correspondent's opposition.

No, "Uncle Harry," I do not forget the civil servants who did not sympathise with Manson's "malaria-mosquito" theory. But I remember them as the type of mind that cannot assimilate a great, simple idea merely because it is new.

Yours, etc.,
ALLAN ST. J. DIXON.

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

April, 1944.

Pass.

R. A. Allen
M. D. Cremin
R. Finney
J. Fry
A. J. P. Graham
W. C. Johnson
R. Merryweather
J. A. Nissim
A. J. P. Oldham
H. A. Philcox
L. P. Ribet
J. C. P. Weber

PART I.

K. D. Allanby
W. F. Belsham
N. J. Bloch
M. J. Blunt
K. R. Brookes
K. A. A. Campbell
A. S. R. Cini
C. B. Clarke
N. R. Fenton
J. S. E. Gilbart
L. W. Godfrey
R. C. Jennings
R. G. G. Jones
T. J. Jones
H. A. Lane
P. C. Leeson
D. O. Lloyd
I. Macdonald
N. K. Macrae-Gibson
E. G. Murphy
D. T. H. Paine
H. W. Palmer, B.Sc.
B. H. Pickard
D. Q. Trounce
J. D. Wallace
N. C. T. Watford
E. A. Wright

PART II.

A. W. Banks
R. F. Barclay
A. B. Dickie
H. F. Hills
J. V. Kent
K. A. Macdonald
N. J. Shah
R. C. W. Thompson
E. G. Wright

CONJOINT BOARD.

FINAL EXAMINATION.

March–April, 1944.

Surgery.

*A. B. Dickie
H. M. Emrys-Roberts
*S. Freedman
I. S. Hodgson-Jones
*J. V. Kent
B. C. Lee
R. G. Lomax
*J. L. F. Maine
J. M. Thomas

Pathology.

C. B. Clarke
*S. Coffey
D. G. H. Davies
I. S. Hodgson-Jones
E. A. Humphrey
H. A. Lane
D. O. Lloyd
I. Macdonald
J. N. Micklem
A. V. Morse
D. P. Nicholson
B. G. P. Oakenfull
D. Q. Trounce

Medicine.

R. G. L. Brittain
*J. Fry
G. J. Haas
*M. D. Keates
J. C. Matthews
D. P. Wheatley

Midwifery.

F. J. Aumonier
H. M. Emrys-Roberts
B. C. Lee
D. J. Morton
H. W. Palmer
B. H. Pentney
N. J. Shah
J. D. Whitehouse

* Have completed the examination.

Higher Degree

J. B. Blaikley, F.R.C.S., has been admitted to the Fellowship of the Royal College of Obstetricians and Gynæcologists.

Awards

M.B.E. (Military Division).

Lieut. C. M. Dave, British Indian Medical Service attached to R.I.N. for great skill in performing operations under very difficult conditions at sea.

Mentioned in Dispatches

Major-Gen. W. H. Ogilvie, in recognition of gallant and distinguished services in the Middle East.

Casualties in the Services

Killed.

Wing-Commdr. R. M. Outfin, R.A.F., in a flying accident on April 29th, 1944.

Wounded.

Capt. P. A. J. Smith, R.A.M.C.

Hospital "Blues"

At a recent meeting of the "Blues" Committee, the following awards were made:—

RUGBY FOOTBALL.

Full Blues.—A. Batty-Shaw, D. C. Boyd, D. L. Gullick, P. D. Harvey, P. S. Hildick-Smith, A. C. Macrae-Gibson, N. K. Macrae-Gibson, R. G. Willcock.

Half Blues.—R. A. Dean, E. W. Graham, I. H. Hilliam, D. G. Jones.

ASSOCIATION FOOTBALL.

Full Blue.—C. B. Clarke.

Half Blues.—I. A. H. Munro, R. Owen, M. J. L. Sykes.

HOCKEY.

Full Blues.—T. C. L. Parry, B. H. Prideaux.

Half Blues.—L. Carton-Kelly, P. C. Dawson, G. Wotton.

SQUASH RACQUETS.

Full Blue.—M. J. Cutler.

Half Blues.—J. D. L. Reinhold, D. R. S. Saunders, J. F. N. Sidebotham.

Births

BROTHERTON.—On May 11th, 1944, at Pitville Nursing Home, Cheltenham, to Eugenie, wife of Major R. W. F. Brotherton, A.D. Corps—a daughter (Sarah).

SIGGERS.—On May 20th, 1944, at the Howard Nursing Home, Maidstone, to Rosemary (née Serraillier), wife of Ft.-Lieut. R. G. Siggers,—a daughter (Susanne Ruth)

Deaths

YARDLEY.—On 16th May, 1944 (of wounds in Italy), G. E. Yardley, Captain, R.A.M.C., 12th Field Ambulance; of Clarence Crescent, Windsor. Memorial Service, Tuesday, 30th May, at the Parish Church, Windsor, at 2.30 p.m.

GRAHAM.—On March 24th, 1944, while on active service, Lionel Augustus Joseph Graham, Lieut.-Col., R.A.M.C.

HALSTEAD.—On May 15th, 1944, at Hill Rise, Rickmansworth (late of Ramsgate), Douglas Vernon Halstead, M.R.C.S., L.R.C.P., aged fifty-four years.

HARVEY.—On May 10th, 1944, Thomas Reginald Harvey, M.R.C.S., L.R.C.P., 2, Park Road, Purbrook, Hants.

STONER.—On April 15th, 1944, Patrick B. Stoner, L.D.S., R.C.S., 18, Regency Square, Brighton, aged fifty-six years.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

IT would be an understatement, perhaps, to say that wars upset things. Not only do they upset our ordinary ways of life, but they upset our notions of the ordering of society, and we begin to realise that in the particular ordering may lie the root cause of war. And so we do our best to change and improve it. Thus is explained the enormous output of suggestions and ideas on various aspects of our society which has resulted in this country, at any rate, in White Papers and Commissions on Education, Finance, Health, etc.

A high wind blowing down Whitehall must have wafted one of these reports in through the portico of the College of Physicians in Pall Mall East (but a stone's throw away), and they, not to be outdone, have produced their report on Medical Education. Unhappily, we have not yet had occasion to read this, but we propose to make a few remarks on that subject all the same.

To begin with, what is implied in the phrase "Medical Education"? "Training in all matters appertaining to the knowledge of medicine and the arts of healing" seems fair enough, and yet we submit that it does not go far enough. Medical education does not cease when we leave our hospital as qualified doctors. It has hardly begun. Medicine is so largely a matter of personal experience that our hospital training is but a novitiate into an order. So vast is the field to be covered and so limited are our means of covering it that we should be foolish to try to assimilate all that knowledge in the few years we spend at a medical school. Instead, we should attempt the broad principles only and cultivate the right approach to the subject lest we become mere technicians and not physicians.

Gone are the days of the Dickensian medical students, "young gentlemen, who smoke in the streets by day, shout and scream in the same by night, call waiters by their Christian names, and do various other acts and deeds of an equally facetious description"; gone, too, are the apothecaries' assistants, but let us beware of becoming slaves of our scientific method, coldly efficient but lacking the warmth of humanism and understanding.

Most of us, when we entered upon our studies of medicine, gave up the "cultural" side of our education and, perhaps, we were very glad to do so. But to many of us the start of a medical education is the start of a new era when we begin to feel the pulse of life, and it is then that our "cultural" education should begin and grow as we grow. It may seem cruel to impose further mental burdens on the already overloaded student, but we submit that the advantages to be gained by the continuance of this aspect of education far outweigh the loss of a certain amount of factual knowledge.

Let us be constructive. A great part of our aim would be achieved if the preclinical years were passed, not at a medical school where all one's fellows pass through the hands of the same teachers, read the same books and have largely the same outlook, but at a university, where medical students are in a painful minority and where you sit at supper with a man on your left who reads History and a man on your right who reads Law, and a man opposite who may read nothing but the racing reports! Such a variety of outlook is scarcely possible in the present medical school system.

In the clinical years, in order to combat this "cultural" isolationism, lectures could be arranged, on a purely voluntary basis, on such subjects as the History of Science, Modern History and Current Affairs. Indeed, over a hundred years ago Guy's students had lectures on Moral Philosophy from Frederick Maurice, an enlightened Chaplain of the Hospital in the 1840's.

You may well lift the cynical eyebrow at all this, but unless some halt is called to all this stuffing of our minds with technical and factual knowledge we shall very soon have some exceedingly inhuman people stepping into our shoes. Scientific medicine is, in itself, no bad thing, but unless it is tempered with the flux of the humanities it has no strength to its purpose.

THE B.B.C. has postponed its broadcast of the special Hospital Sunday Service from the Hospital Chapel on June 11th, but it is hoped that it may be broadcast at a later date instead.

WE print in this issue of the *Gazette* an important letter on the rebuilding of the Hospital. Plans and models of the proposed new buildings have been prepared and are soon to be seen by those who are interested.

Many who read this letter will have no opportunity of seeing these plans, so we hope to print a few photographs of the model that they, too, may offer their criticisms and suggestions, for that is one of the main purposes of the model. Therefore, we invite letters from readers on this question of rebuilding now that we have some concrete ideas upon which to base our criticisms.

WE should like to apologise for the slimness of this issue but transport difficulties have held up our paper supplies temporarily.

For Practices That Yet May Be

BY EDWARD SAMSON, L.D.S., F.C.S.

(*Concluded.*)

We now approach an aspect of dental practice which has caused as much discussion as the cause of caries with as little satisfactory conclusion—namely, the subject of fees. Fees are probably the most vexed of all questions—more vexed even than the patients who have to pay them. There was a time, not long distant, when fees were treated like Victorian legs; they were acknowledged to be necessary as a means of support, but quite unmentionable in polite circles, and no professional gentleman would risk his dignity by discussing so sordid a matter. He might mention his bad debts without loss of caste, as the more of these he had the more likely he would be regarded as a public servant of high-minded views who was slaving for his patients for a mere pittance. But to mention profits was in the worst of taste and, more horrible, to explain how he obtained them was the gravest vulgarity. Happily this attitude is changing and all these disquieting subjects are acceptable under the euphemistic heading of dental economics, while a few really enlightened men have discovered that even dentists live by the money they earn, and the sum total of that money is in some measure an indication of their success. Indeed, the end of regular periods should produce audited accounts from which the financial progress of the twelve months' work may be measured. Nor is it only financial progress which is so discovered. A carefully prepared balance-sheet is a mine of information for the man who wishes to control those parts of his practice not immediately operative.

As to individual fees there is only one point on which all dentists agree—that they should always be higher. For the rest—how they should be charged and estimated, whether on a time basis or an itemised scale—the views are consistently at variance, each protagonist strongly upholding his own theory with more obstinacy than reason. By far the most general custom is the catalogue or fixed price-list system, somewhat akin to a barber's list of charges in which every separate item of treatment carries a stated fee, published for all to see just as in the case of a shave, a haircut or shampoo, and from which the patient (or customer) takes his choice according to his whim or pocket. This is, of course, the merest trading of merchandise, and that is why dentists are still crying out for improved status, dignity and respect; for so long as they sell fillings at so much each, extractions at a fixed rate and dentures priced according to the colour or texture of the material used, so long will they be regarded as tradesmen in white coats. Indeed, at times the uniform becomes uncomfortably like that of the barber or Sainsbury's assistant.

Perhaps the best system at present in general use is arriving at a fee in terms of time spent, for it carries the distinct benefit of not having to hang price labels upon articles; thus the patient learns to realise that the dentist working to this system is offering only his time, not vulcanite by the inch or amalgam by the ounce. Against this the method still does not put a premium upon his skill and knowledge, for unless every minute of an appointment is occupied in operative work or constructive consultation the patient will feel she is paying for the ticking of the clock. To charge a fee for an hour, half of which is spent in discussing the second front turns an appointment into a disappointment, and the patient will rightly begrudge the use of two visits where one might have sufficed.

I have previously quoted the case of the dentist who charged seven guineas an hour for his time. His ledger was crammed with details of conversation and minor operations which could never have justified any charge, let alone his very high ones. The failure with the time-fee method lies in its inability to convince the patient that every minute is productive—that is for her, not alone for the dentist.

I have often been asked by students what fees they may expect to receive. The obvious answer is, "*What your work is worth*"; and, judging by my own capabilities when I left hospital, the further reply would be, "Nothing." I hasten to add that I am sure every newly qualified dentist in these advanced days is possessed of the highest skill. If he is not, then the board of examiners make many a grave mistake. Yet there is a vast difference between constructing a perfect, cohesive gold filling in three hours to the satisfaction of the examiners and producing competent work in twenty minutes, or less, to the satisfaction of a patient. That is exactly upon what the nature and estimation of a fee rests. A satisfied patient will pay a reasonable fee without complaint if she knows beforehand what it is to be, and for what service. To a dissatisfied one any fee is exorbitant. Therefore, the fees obtainable depend entirely upon the dentist's ability to convince his patients that the treatment they receive is the best, and most convincing of all arguments is to provide the best. That is why it is such hypocrisy, not to say poor tradesmanship, to sell varying grades of prosthetic or conservative work.

To offer the patient the choice of a gold inlay or an amalgam filling is no different from offering two grades of socks over the counter. Likewise, to display a selection of dentures, varying from gold in the luxury class to dark brown vulcanite in the utility grade, is not dentistry but shop-keeping. As well imagine the surgeon suggesting finer or coarser gut to stitch the incision according to the patient's whim or pocket. How there can be any alternative to correct conservative or prosthetic treatment is hard to explain. The patient must be told what is desirable and necessary treatment, and understand that the suggestions made are the result of a careful diagnosis and therefore unalterable. That being agreed, the fees are then decided upon. At no time is the patient the judge of the type of operation. There is only one suitable treatment for any particular condition—that is the one dictated by the dentist's knowledge; not by the pressure of his creditors. To degrade his training by reducing the position to a commercial transaction at once places him at a disadvantage, and thereafter the patient loses confidence and has as much faith in him and his judgment as in her tradesmen—no more, and rightly so. If the circumstances of a mouth demand a metal denture it must be fitted regardless of the few shillings more it may cost. If, however, the fee is beyond the patient it can either be reduced or the treatment not provided. Emphatically cheaper or lower standard work must not, cannot be suggested—for that way lies ultimate failure. Dentistry cannot be turned into successful business, neither is it even sound economics to sell skill in terms of goods. But sound economics may well be adapted to the selling of knowledge and skill, qualities the patient is incapable of choosing.

There are other ways of estimating fees, but it is between these two usually accepted methods, itemisation or time-basis, that the choice averagely falls. However, there is yet a further solution of the problem which I have called the unitary system. It has the advantage of harmonising a dignified economic approach to our work with a sound economic philosophy. When I am adversely criticised for this theory I usually admit that, part of it at least, originated in America. When it is praised I claim it as mine. In actual fact there is nothing startling or ingenious about it. It is merely the proper conception of his duties by the dentist, based upon correct, scientific diagnosis and treatment. I am only surprised that it has not been the customarily adopted system long before this; it is so obviously suited to every grade and feature of our work.

While it is not possible here to dwell upon the entire theory, I would like to explain how it can be utilised in order to solve the problem of fees—finally and with simple dignity.

In the first place the mouth should be conceived as what it is—a masticating machine which is one, indivisible unit, not capable of being divided into parts of thirty teeth or less. Nor should these separate teeth be looked upon as isolated objects, each waiting to be filled, extracted or replaced at so much per item. The standard the dentist ought to set himself and, more important, impress upon his patient as the ideal of treatment is that of rendering the mouth functionally sound as a masticating machine with the highest possible co-efficient of mastication. With this object the first step, either as an indispensable aid to diagnosis, or, in relation to our present considerations with the intention of estimating fees, is to obtain study models. Without these no mouth can be accurately diagnosed ; no dentist can discover all its deficiencies, nor the patient become intelligently aware of the value of the required treatment. Furthermore, it is safe to say that if closer attention were paid to maintaining correct occlusion and a full potential of articulation fewer cases of caries, and certainly of pyorrhœa due to stagnation areas and traumatic occlusion, would arise.

Now, in regard to estimating the fee, the study models having been taken and the mouth having been carefully examined all essential treatment is noted. Cavities, gum condition, bite pressures, edentulous spaces, and every abnormal state is formed into a total of diagnosis, the fee for correcting which is quoted as one total. The patient is told that it will cost so much to put the mouth in maximum, functional condition. This at once obviates any possibility of her choosing urgent fillings or extractions because she can afford them or desires them, and leaving that part of the work which she regards as too costly or not quite so important. All treatment is necessary. If it is not, it should not be proposed. Neither is there such a thing as luxury and utility dentistry despite what we hear of such classifications. By quoting a total fee the patient is led to realise that the mouth is being treated as one indivisible unit and, by employing this method, the dentist begins to conceive his duties in that ideal way. If then the fee proposed is not agreeable to the patient—that is, too much (it will never be too little)—a sum may be deducted from the total to meet the circumstances ; but never, by this method, can an item of the treatment be omitted as a financial adjustment. In other words, the standard of dentistry is not dropped or regulated to comply with economic considerations, while the patient begins to appreciate that dentistry is something more than a process of scratching around for holes and extractable teeth or of selling dentures to fill spaces. This system also eliminates the now prevalent habit of patients asking, or demanding, a scaling prior to going to a dance or a filling in a front tooth while the molars are rotting. The dental surgery at one step ceases to be a shop or beauty parlour and becomes, instead, a consultation room.

Before showing you a pictorial explanation of the unitary system, I would like to outline a few salient rules indispensable to proper practice organisation.

First, all records should be accurately kept, regularly entered and frequently consulted. In this way the dentist always possesses an up-to-date knowledge of his progress or otherwise. There are many simple forms of book-keeping, but it is wisest to obtain a method from the accountant employed for the auditing—a man most valuable to the dentist, for he will take over full responsibility for all the intricacies of auditing and, more important, relieve him of the distasteful correspondence which so regularly flows between the dentist and the Commissioner of Taxes.

Only hopeless muddle can result from entering ledgers and records in spare minutes when patients fail to arrive or on fire-watching nights. There must exist a precise programme for this, as also for rendering accounts, which, in my opinion, should be monthly. In the grand, leisurely old days when gentlemen owed more to their tailors than to their intelligence, and nearly as much to their dentists, accounts were sent out quarterly, even annually. It is a far better scheme to despatch them monthly, and, contrary to opinion, this does not create offence. The patient who intends to pay will not take exception to receiving a bill, while the one who is dilatory is best reminded frequently. And the patient who is determined not to pay has no feelings to consider.

May I also impress upon you the advisability of joining a professional protection society ? Even students who qualify in these times of superior technology are liable to commit errors of operation and judgment, only one of which is required to ruin a good practice or hard-won reputation. Such societies take full legal and financial responsibility for their clients—often conduct all the unpleasant formalities of these

cases, and freely advise the dentist in his best interests, apart from paying any damages that may be awarded against him. There are few practitioners who have not had occasion to be grateful to a protection society at some time in their careers.

It is obviously impossible to cover more than the smallest fraction of practice management within the brief space of this address. I hope that what little I have said may stimulate a discussion lively enough to bring forth greater ideas than mine. Whatever befalls you in the economic future you have one consolation—a dentist cannot be one of his own creditors.

Farnborough Letter

IT would appear that about five months have elapsed since the last edition of this letter appeared. In that time the Hospital has lost most, if not all, of its appearances as a Guy's Sector, with the disappearance of yet more of the Nurses. Now only two wards and the "Huts Theatre" remain staffed by Guy's, so that the familiar mauve uniform is becoming a rare sight indeed.

Major changes in the resident staff have come about during the last few months with the transfer of Dr. Thomas from his country haunts to the Mother Hospital. His place has been taken by Dr. Forgacs, late of the Brompton Hospital. Before we forget, we would take this opportunity of congratulating Dr. Thomas on obtaining his Membership.

Mr. Rawlings has, unfortunately, left us for the Army after a long period of subtleties in the Mess, his position as resident anæsthetist being taken by Mr. Wilshere from Orpington.

Of the more junior staff, MacCallum has left for Joyce Green; Ellerker has joined the wavy Navy; whilst we would welcome Macrae-Gibson (and plaster) and Allen. Finney paid us a ten-day visit before being called away somewhat unexpectedly to the *Salt Mines at Gravesend*!

Recently the invigorating sight of a pathologist in jodhpurs has been seen around the hospital, along with mutterings of "hands, hocks and withers," as he chases the wary Staphylococcus round the Lab. Whether or not there is a horse at the bottom of all this no one has found out yet, but rumour has it that he is to start a buggy service to the "Queen's Head," Downe.

Last, but by no means least, we would congratulate Dr. and Mrs. Gartside on the birth of a son (Jonathan Francis) at the hospital. PEE-BEE.

Correspondence

REBUILDING OF GUY'S.

To the Editor of the GAZETTE.

SIR,—For some time a Joint Committee, consisting of Governors and members of the Honorary Medical Staff and of the Medical and Dental School Staffs, has been considering the future of Guy's after the war. It is, of course, obvious to everyone that a considerable amount of rebuilding will have to take place, and in this connection the Governors recently appointed Mr. Alner W. Hall, F.R.I.B.A., of the firm of Messrs. Young and Hall, Architects, to prepare sketch plans for providing the accommodation which the Joint Committee had decided would be desirable.

These first plans are nothing more than an effort to show the amount of building which would be required and the necessary site, and the first object in preparing these drawings is to have something with which to approach the Boroughs of Southwark and Bermondsey and the L.C.C. Town Planning authorities. It is obvious that the existing site of the Hospital would be inadequate, and owing to proposed new roads very little extension was possible on the Borough High Street side of the Hospital; it is apparent, therefore, that further ground must be sought across Maze Pond, and that permission to close certain roads must be obtained.

The first plans and model of the proposed building have now been prepared and will be on display in a room on the ground floor of the Nuffield Nurses' Home from Monday, June 12th, to July 31st, and the Court of Governors extend a hearty invitation to all interested to visit this exhibition. Anyone wishing to make any criticisms or suggestions is asked to submit them in writing to me, and it would help the Court if the writer would state his or her connection with the Hospital. Anonymous communications cannot be considered.

I am instructed to emphasise that these plans for the rebuilding of Guy's have not been approved or even considered by any of the Committees or Authorities of the Hospital, and are simply the first effort of the Architect to sketch out what buildings will be necessary to give the accommodation it is thought the Guy's of the future should have.

Yours, etc.,

B. LEES READ,
Clerk to the Governors.

NATIONAL HEALTH SERVICE

To the Editor of the GAZETTE.

SIR,—In "Passim" on May 27th you deplore the apparently apathetic treatment of the White Paper at Guy's. In the same issue your correspondent, Mr. Dixon, criticises "Uncle Harry" for writing his opinion on the same subject without revealing his identity, but surely "Uncle Harry" has contributed to your columns sufficiently often to be an acceptable opinion. I do not know the identity of "Uncle Harry" any more than I know Mr. Dixon. I surmise that "Uncle Harry" has had some experience of the conditions he exposes, but Mr. Dixon appears to me an inexperienced idealist who is prepared to accept at face value all he wants to believe. What have the bureaucrats so far done to reassure us that this "great simple new idea" will justify us in handing over all that is good in our profession; they do not even offer us central medical control, and what can the lay mind know of the intricate differences of individual patients—even when they are suffering from a disease of the same name! Nobody will disagree that there is need for improvement in our medical services, but, before we abandon the old, we should first be assured of the advantages of the new or, at most, undertake the trial of a compromise. But do Mr. Munro and Mr. Dixon consider their expectations of Utopia are supported by the Tuberculosis or V.D. Schemes already provided by the State? Except for the coincidental development of new drugs, for which the State is not responsible, and modern environmental factors, are the benefits apparent?

If it is not for some political reason, why this urgency for the introduction of a re-organised medical service in the middle of the greatest war in history? To detract attention from this fundamental point so much has been said of the disadvantages to the individual doctors, but I suggest that as a Profession we should consider the disadvantages to the individual patient who, given a reasonable alternative scheme, would prefer that the doctor of his choice is still available for any emergency day or night and that his doctor retains the status of respect and confidence which is part of our national family life. This can hardly be expected in the mediocrity which must eventually result from the present estimated cost of the suggested scheme of £30,000,000 per year: as Mr. David Eccles, in the *Evening Standard* and *British Readers' Digest* (Vol. 15, p. 55) has pointed out, this figure will offer the General Practitioner a salary of from £500 to, at the most, £900 a year. Such provisions, he points out, will be acceptable to the minority—"the lazy and the saints." Most doctors are neither (yet) and, being human, however high their ideals respond to the appreciation and remuneration of their extra services. When the individual demands his "rights" it will be harder to maintain the present relationship, and what kind of a man would in future be attracted to this state of servitude?—those who seek a safe living and are prepared to raise no criticism in carrying out their prescribed essential duties. If medicine could be administered by robots to robots the White Paper would be a brilliant scheme, but one day Mr. Dixon will learn "all is not gold that glitters."

Knowing that Mr. Dixon will expect me to bear the onus of proving my opinion I could enlarge on the restriction of drugs available for treatment in certain Council hospitals, of a Council Superintendent's power to override a visiting consultant's incon-

venient diagnosis, of regulations that forbid the provision of medicines for the continuation treatment of discharged convalescent patients, of the stop-watch indicated for the timing of the actual number of minutes spent with patients on sessional visits, etc. But your space is valuable and, suffice it to say that these examples are some of the disadvantages of which I have had personal experience and of which I would be prepared to submit details if proof is desired. No doubt a *part-time* medical service on a voluntary basis would bring vast improvements; it should be possible to introduce a scheme similar to the New Zealand Medical Service, but it is my opinion that a full-time service would be a most serious retrograde step in the national health.

Yours, etc.,

DAVID ERSKINE.

Guy's Hospital, S.E.1.

Sport

Cricket

GUY'S *v.* PUBLIC SCHOOL WANDERERS.

(*Played at H.O.P. on May 6th.*)

Result: The Wanderers won by five wickets.

With Murphy and Saunders playing for the United Hospitals at Lord's, the Guy's side was not up to full strength. The Wanderers won the toss and put the Hospital in. Burbridge and Holmes opened, the former shaping well but losing his wicket with the score at 25. Thompson's first stroke—a fine drive through the covers—showed centurian quality, but no further promise was evident and he soon returned to the pavilion. It was left to Trist to save an ugly situation by scoring 33, his innings being left unfinished, due to the untimely departure of the other batsmen. The Hospital bowling, although steady, was not dangerous and the Public School Wanderers gained their runs with the loss of five wickets and with ten minutes to spare. Trist, again, deserves mention for his bowling, taking three wickets.

Keenan's leg-break bowling; Allsop's brisk 31; and a steady innings of 42 not out by Wall were the best performances on the Wanderers' side.

Team.—L. D. Carton-Kelly, G. Thompson, D. J. Sheerboom, P. S. Holmes, I. G. Burbridge, J. E. Attale, D. Nicholson, J. R. Timms, K. G. Pritchard, A. E. Trist, J. D. Whitehouse.

GUY'S *v.* OVERSEAS H.Q. (R.A.A.F.).

(*Played at H.O.P. on Saturday, May 13th.*)

Result: Drawn. R.A.A.F., 148 for three wickets; Guy's, 148 for nine wickets.

On a day which started with tropical heat and ended in nothing short of a blizzard, Guy's batted first. A fine innings of 45 by G. Thompson, aided by Murphy and Sheerboom with 24 apiece, brought the Guy's total to 131 for five wickets, when rain temporarily stopped play. Tea was taken, after which Guy's continued to bat for another twenty minutes, but could only add 17 more runs for the loss of four wickets.

When Guy's took the field in the teeth of the gale they could do little against the Australian batting. Donnar (39) and Staines (71 not out) got together and began punishing anything short of a good length and quite a lot besides. However, they were unable to pass our total and, on the last ball of the game, Clacher sent the ball to third man for two, making the totals the same,

Team.—E. G. Murphy, L. D. Carton-Kelly, G. Thompson, J. D. Whitehouse, D. R. S. Saunders. R. Finney, D. Nicholson, A. E. Trist, D. J. Sheerboom, W. A. Evans, M. J. L. Sykes.

GUY'S *v.* BROMLEY TOWN.

(*Played at H.O.P. on May 20th.*)

Result: Won by eight wickets.

Bromley batted first on what appeared to be a plum wicket, but were soon in trouble from Murphy's bowling, four of their wickets being down for 10 runs. Collapse was avoided by Cheeksfield and Pocock, who added 30 runs for the seventh wicket, but in spite of this they could only muster 64 runs.

Guy's passed this total with eight wickets in hand, and from then on what was virtually a practice game ensued, and at the close of play the Hospital had 252 runs on the board. Garland (27), Murphy (69, retired), Thompson (31), Boyd (32 not out) and Brittain (38 not out) were the main run-getters.

Team.—E. G. Murphy, L. D. Carton-Kelly, G. Thompson, G. W. Garland, R. G. L. Brittain, D. C. Boyd, A. E. Trist, D. J. Sheerboom, I. A. Munro, W. A. Evans, D. Nicholson.

GUY'S *v.* CANADIAN MILITARY H.Q.

(*Played at H.O.P. on Saturday, May 21st.*)

Result: Won by 156 runs.

The Canadians won the toss and put the Hospital in. Against a none too strong attack Trist and Lambert scored quickly, the former returning to the pavilion having scored 29 runs. After half-an-hour's play Murphy and Graham came together and stayed so throughout the afternoon in a stand of 141 runs. When Graham was bowled by Joyce for 61 and the innings declared closed, Murphy was still undefeated with 88 to his credit, including seven 4s.

The Canadian batting did not suffice to master the Guy's bowlers and they were dismissed for 32.

Team.—E. G. Murphy, L. D. Carton-Kelly, G. Thompson, D. Nicholson, E. W. Graham, K. G. Pritchard, F. R. Lambert, J. D. Williams, I. G. Burbridge, W. A. Evans, A. E. Trist.

GUY'S *v.* OLD RUTLISHIANS.

(Played at Merton Park on Saturday, May 27th.)

Result: Lost by two wickets. Score: Guy's, 67; Old Rutlishians, 73.

Guy's batted first on a fast wicket, which crumbled on immediate use, and were soon in trouble. Munro, Whitehouse and Thompson had returned with only 12 runs on the board; but Murphy, as usual, managed to remain almost throughout the innings for 29, being finally defeated by Spinks. Nicholson, who played one stroke for his six runs; and Pritchard, who was undefeated at the close were the only other batsmen who were able to cope with the difficulties of the wicket.

The Old Rutlishians fared little better against the fast bowling of Trist and Parsons, and at tea-time had only reached 34 runs for the loss of five wickets. After tea the same bowlers carried on for a few overs before Murphy replaced Parsons, delivering rather an expensive over. Carton-Kelly followed Murphy and rapidly dispensed with the last three batsmen, but not before they had passed our total with two wickets in hand. Trist bowled very well throughout the innings, ending with the fine figures of six for 32.

Team.—E. G. Murphy, G. Thompson, D. Nicholson, I. A. Munro, E. W. Graham, J. B. Parsons, L. D. Carton-Kelly, J. Whitehouse, A. E. Trist, D. J. Sheerboom, K. G. Pritchard.

Hospital Information, etc.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

May, 1944.

Surgery.—*P. W. T. Hollis.

Pathology, Bacteriology and Forensic Medicine.—M. J. Blunt, *P. W. T. Hollis, D. T. H. Paine, *A. G. Wolstenholme.

Medicine.—*A. M. Earle, *P. W. T. Hollis, E. H. Osborn-Smith.

Midwifery.—A. St. J. Dixon, *P. W. T. Hollis.

* Have completed the examination.

Papers by Guy's Men

Rumsey, H. St. John. Aids in the Treatment of Patients with Defective Speech. *Med. Pr.*, 1944, **211**, 139.

Worster-Drought, C. Cerebrospinal Fever. Diagnosis. *Post Grad. Med. J.*, 1944, **20**, 99.

Ogilvie, W. H. Forward Surgery of Abdominal Wounds. *Lancet*, 1944, i, 555.

Barber, H. W. Sulphonamides in Dermatology. *Practitioner*, 1944, **151**, 281.

Appointment

Air Vice-Marshal A. F. Rook, O.B.E., has been appointed an Hon. Physician to the King.

Change of Address

J. K. Donald, Surg.-Lieut. Cmdr. (D.), R.N.V.R., c/o The Admiralty, S.W.1.

E. C. Gallagher, Lieut.-Col., R.A.M.C., A.D.M.S., 21 Army Group, No. I.A.P.D.C., London.

L. C. Thomson, M.R.C.S., L.R.C.P., Charlwood, Leigh Road, Hildenborough, Kent.

John Tudor, L.M.S.S.A., Cornerways, Grenfell Road, Maidenhead.

G. N. Wood, Lieut.-Col., 9th Field Ambulance, A.P.O.

G. E. Aling, Major, I.A.M.C., O.C. 361CD (I.T.), Indian Command.

C. S. Darke, Major, R.A.M.C., 53 (E.A.) C.C.S., East Africa Command.

M. Suskin, L.D.S., R.C.S., O.P. Box 8919, Johannesburg, South Africa.

Prisoner of War in Japan

Miss Kathleen M. Jenkins (Guy's, 1926–30).

Missing

It is with deep regret that we record that the following are now presumed to have been killed in action at sea:—

Major Richmond Edwards, R.A.M.C., November, 1943.

Miss Barbara E. Leech, S.R.N., Q.A.I.M.N.S.R. (Guy's, 1938–42), February 12th, 1944.

Births

TILL.—On May 30th, 1944, at 27, Welbeck Street, W.1, to Margaret (née Crust), wife of Major S. Jameson Till, M.C.—a brother for Susan (Michael Anthony).

UNSTEAD.—On May 11th, 1944, at Ladysmith, South Africa, to Nancy (née Bradford), wife of Captain R. Unstead, S.A.M.C. (D.)—a son.

Deaths

FOURAKER.—On May 25th, 1944, in Westminster Hospital, following an operation, Leslie Frank Fouraker, L.D.S., R.C.S., 29, Central Hill, Upper Norwood.

GRIFFITH.—On May 24th, 1944, Harry Dermott Griffith, L.D.S., of Dudley and Stourton, in his sixty-sixth year.

PARROTT.—On May 23rd, 1944, Hugh McDowall Parrott, M.B., B.S. (Lond.), M.R.C.S., L.R.C.P. (Lond.), of Martins Wand, Blackheath, Guildford.

PIKE.—On March 12th, 1944, Norman Howard Pike, M.B., B.S., of 6, Charlton Park Gate, Cheltenham.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE millions termed the Allied Nations must all at this time be applauding the efforts of the leaders of the United States and the British Empire (*toujours la politesse*) on the initial success of a campaign whose scale and complexity are unparalleled in history. One wonders at the courage of these men who, when the whole world realised that the Allies had been defeated and when this nation was left nothing but a despairing faith in victory, must already have started to prepare for a distant assault on the Continent. Their plans were, no doubt, founded on facts—facts which were not known beyond the select few, facts giving certain prospect of their ultimate fulfilment. Once again in history success has been accorded to leaders who were great enough to view the past, the present and the future in their true perspective.

In our last issue notice was directed to plans for the rebuilding of the Hospital after the War. We were delighted to find that the committee considering the question had, indeed, taken the broad view. Nothing must be spared in the development of the site. Previously we had been tempted to picture a hospital in the country, where the lovable, yet far from laudable, aromas of the Borough, with its breweries, its hops and the near-by fish market were replaced by the more bracing and untainted atmosphere of the Weald. It was, however, a hospital little larger than the present Guy's, its unity remaining unbroken by overwhelming size. The Borough site became a casualty clearing station, Front Surgery, a park and a museum. Other centres were set up in more distant areas and between each and the parent Hospital ran ambulance services—yes, even air ambulances seemed not impossible—so that all patients could, when necessary, reach the Hospital within half-an-hour. On visiting days private 'buses were in evidence and the relations of those more seriously ill had quarters in the Hospital reserved for them. And Out-patients ? Well, few now lived just round the corner following the L.C.C. housing developments and the journey south was short. Harley Street remained ; the Royal College of Physicians was still far from the Hospital. Consultants would cry " Impossible ! " at the prospect of such travelling, only to find their homes literally next the Hospital grounds and no further from their consulting rooms than their present country houses.

But they would require the courage of a Churchill who would embark on such a scheme, even should they accept it as desirable and the proposed schemes for the extension of the Hospital on its existing site are themselves imaginative. So let the place be accepted and at some less harrowing time, in a saner frame of mind, we will apply ourselves to its more detailed development.

NAMING D-Day has proved to be as tantalising as spotting the Derby winner (!) and at Guy's, the first certain lead, were one astute enough to grasp it, was the departure of some members of the X-ray staff for service at casualty hospitals. That was the day before (D-1) and they were followed forty-eight hours later by a number of students. They all carry the good wishes of the Hospital, and we look forward to hearing of their experiences; at the same time nearly everyone will admit to being "green with envy."

A FURTHER feather in the Guy's cap has been the appointment of Sister Scales to the Council of the Royal College of Nursing. We proudly congratulate her, especially as this honour has never before been conferred on a Ward Sister.

Some Notes on Penicillin

By R. N. SCHULLINGER Lieut.-Col. M.C., U.S. Army

(Subsequent to this article being written we have to congratulate Professors Fleming and Florey on the honour of Knighthood.—Ed.)

(This report is not an original paper, but rather a compilation of data gathered from the literature, together with a certain knowledge we ourselves have acquired from a somewhat limited experience with penicillin. We take this opportunity in acknowledging our very sincere thanks to Professor and Dr. Florey for their kindly, unselfish and generous assistance in guiding us with the treatment of our first cases. Similarly, we also desire to thank Professor Colebrook for explaining and demonstrating his method of penicillin therapy in the care of infected burns at the Royal Infirmary in Glasgow. These kindnesses are but two of innumerable instances reflecting the cordial relationship betwixt our nation and this great Empire.

BY reason of a fortuitous circumstance, combined with a keen observant eye and an alert mind—thus eliminating the factor of mere chance or luck—Fleming noted the anti-bacterial power of the mould, *Penicillium notatum*, upon a contaminated culture plate. This was in 1929. He made further studies and found that the mould elaborated a substance, a metabolite, which arrested bacterial growth, and called it "penicillin." Fleming then demonstrated the value of penicillin in selective culture media for isolation of *H. influenzæ* and *H. pertussis*, and predicted its use for practical therapeutic purposes in the treatment of infections and septic wounds. Two years later Clutterbuck, Lovell and Raistrick developed a medium favourable to the growth of *Penicillium notatum*, and a number of modifications of this medium have been evolved since then. The optimum temperature for growth of the mould is 24 deg.C. However, no means of preparation for experimental and clinical use was discovered until Professor Florey and his co-workers took up the problem in 1937. After painstaking efforts and almost insurmountable difficulties, a preparation was finally produced which Professor Florey considered safe and sufficiently pure for scientific study. Then came the period of animal experimentation and clinical trail which almost failed. The rest of the story you know.

PHYSICAL PROPERTIES.

Penicillin is an unstable acid, not a protein. The calcium or sodium salt, as it is prepared to-day, is a yellowish brown to reddish brown powder, extracted from the brew. The latter is treated aseptically to avoid contamination by other organisms, and the extraction is an extremely laborious and painstaking process. One Oxford unit is the smallest amount of penicillin which, when placed in 50 c.c. of a meat extract broth culture, will inhibit the standard strain of staphylococcus. The calcium salt is for local application only. The powder is about 10 per cent. pure, the rest being "muck" as Professor Florey calls it, consisting chiefly of pigment (chrysogenin) and pyrogenic substances. Penicillin deteriorates at ordinary temperatures and is destroyed at 52 deg.C. At 25 deg.C. it remains active for twenty-four hours, and at 37 deg.C. it perishes in about three hours.

In solution at 0–5 deg.C. it will keep for a week, probably a month. The sodium and calcium salts remain relatively stable between *p*H 5 and *p*H 7 (optimum 6.8), are markedly hygroscopic, and rapidly lose their activity if exposed to air. They are inactivated by acids, alkalis, heavy metals, oxidising agents, the primary alcohols, and enzymes (except pepsin). Being extremely soluble in water, a good vehicle for administration is either distilled water, or physiological saline, with or without 5 per cent. glucose. Once synthesis is accomplished the chances are that some of its chemical derivatives may prove to be even more potent. Meanwhile, about 110 other moulds have been examined for anti-bacterial properties.

ACTION ON BACTERIA.

For staphylococcus, streptococcus, pneumococcus, meningococcus and gonococcus it is strongly bacteriostatic; also B. anthracis, C. diphtheriæ, Actinomyces bovis and M. catarrhalis are known to be sensitive.

The Welch clostridium, also Cl. œdematiens and Cl. septique *in vitro* are just as sensitive to penicillin as staphylococcus aureus. The proteolytic clostridia are four to five times more resistant. Other susceptible organisms are Treponema pallidum and the tetanus group. Recent reports indicate that some strains of streptococcus viridans

are also sensitive. We have treated a case of streptococcus viridans osteomyelitis of the mandible in which the sensitivity of the organism equalled that of the standard staphylococcus strain. Penicillin exerts no bacteriostatic action on the Koch bacillus, the coliform group, B. proteus, diphtheroids, brucella, hæmophilus, Ps. pyocyaneus, B. Friedlander, enterococcus and V. choleræ.

Even in considerable dilution it will inhibit growth of many strains. Florey found some strains of staphylococcus aureus sensitive to dilutions of pure penicillin at 1/60 million. It appears to have no deleterious effect on tissue or tissue cultures even in high concentrations, far higher than comparable strengths of the dyes, iodine, phenol, Hg., Dakin sol. etc. A recent investigation of Hamre, Rake, McKee and McPhillamy discloses a local tissue damage at the injection site in laboratory animals, especially guinea-pigs.

Some bacterial strains are evidently resistant and we have encountered three such instances. Since Professor Florey's visit to North Africa he found about 4 per cent. of the staphylococcic strains to be resistant; of the twenty-six or twenty-eight families of gonococci, one or two are probably resistant. Moreover, a susceptible strain can acquire resistance through insufficient dosage, and this is particularly true in the case of staphylococcus. If it becomes penicillin-fast, this occurs usually during the first week of treatment, rarely later. The streptococcus resistant strains are more apt to be viridans and enterococcus, yet not all of the former are resistant.

Powell and Jamieson, McKee and Rake state that penicillin-fast strains of pneumococci not only lose their virulence, but are actually rendered susceptible to the sulfonamides; on the other hand, the *sulfa* resistant strains of pneumococci *retain* their virulence but become susceptible to penicillin.

McKee and Houck then went a step further and studied the degree of acquired resistance of organisms to penicillin :—

Staphylococcus aureus : 1,000 to 6,000-fold resistance.

Type III pneumococcus and streptococcus pyogenes : 30-fold increase in resistance.

Type I and II pneumococcus : only a 6-fold resistance.

The decrease in virulence was proportionate to the degree of resistance, by mouse experiments, so that Types I and II pneumococcus retained most of their virulence. The lowered virulence seems to be permanent, the rate of growth is retarded, and the colony type becomes more variable.

It is generally believed that penicillin is bacteriostatic and not bactericidal, and Professor Fleming has demonstrated this quite conclusively. Gardner states that it inhibits bacterial division. However, Rammelkamp and Keefer are inclined to believe from recent experiments that penicillin may possess some bactericidal power as well.

PHYSIOLOGY.

In general, it is quickly absorbed and rapidly excreted especially by way of the kidneys, nearly 60 per cent. being eliminated in the urine, and, with practice and technical skill, about a quarter to a third of it can be recovered. However, it is an expensive procedure and ordinarily is not employed unless many cases are under treatment in the same institution. Incidentally, and of some clinical importance, it is easier to maintain higher blood levels of penicillin in patients with evidence of some renal damage. We have examined the urine for albumin and casts and red blood cells every second or third day in our cases under treatment, and thus far have found no evidence of renal irritation. Some penicillin is also taken up by the liver and excreted into the bile. None has been found in the pancreatic or lachrymal secretions and only a trace in the saliva. Very little penetrates the erythrocytes—less than 10 per cent. Once in the blood stream it can diffuse rapidly through the tissues, but it does not appear to pass into the cerebrospinal system in any appreciable amount. When injected directly into the spinal canal, joint spaces, or pleural cavity, some of it remains for twenty-four hours or longer. However, when the meninges are inflamed, it is absorbed more rapidly. Penicillin is not inactivated by pus, body fluids, serum, blood, peptones or autolysed tissues. It does not inhibit the activity of the leucocytes, but rather enhances their phagocytic proclivities. There is no destructive effect upon human tissues in general, but the sodium salt, in powder form, is irritating, when applied locally and undiluted, to wounds and burns. Therefore, if high concentrations are desired for local application it would be wiser to resort to the calcium salt, if obtainable. Parenterally administered, penicillin has little effect upon large abscesses or large bone sequestra; the former should be incised and drained; the latter excised.

Extensive slough or necrotic tissue also necessitate surgical removal. Suppurating serous cavities require proper surgical treatment; also "dead spaces" and sinuses with thickened avascular fibrous tissue walls.

The rate of absorption differs according to the route by which it is given :—

Intravenous : Very rapid rise in blood level followed by a rapid fall.

Intramuscular : Rapid rise in blood level, slight plateau, relatively rapid fall.

Subcutaneous : Uneven rate of absorption ; possibly some local tissue damage, too.

Oral : Unreliable because of destructive action of HCl. Rapid absorption from duodenum.

Rectal : variable because of action by bacterial enzymes.

Therefore the last three routes are undependable in maintaining blood levels. The ideal preparation would be some intramuscular solution which permits a slower and more even rate of absorption. However, one can maintain a higher blood level by the continuous intravenous drip. Advantage : does not permit bacteria to recover sufficiently (between doses) to develop a resistance. Disadvantages : too much dosage. Local thrombosis. Some cases of pulmonary infarct following lower extremity thrombophlebitis have been reported. Therefore choose the arm veins for intravenous therapy, if possible.

There are probably no toxic reactions. Those reported in the literature are due, in all likelihood, to impurities in the "muck." Chills, with or without fever, have been described in connection with intravenous injections. In one series urticaria developed in 5.7 per cent. It had no time relationship and did not necessarily recur with subsequent courses of penicillin therapy. Fever and abdominal cramps frequently accompanied the urticaria. On the other hand, fever without urticaria was sometimes noted during the first three to five days of treatment. Eosinophilia up to 20 or 30 per cent. has been found in a few cases. Headache, myalgia and muscle cramps have also been described. Some patients complained of flushing of the face and burning at the injection site. However, we treated one case with daily dosages of 240,000 units without any toxic manifestations, and the U.S. Army Medical Bulletin for November, 1943, reports a daily dosage of 600,000 units without any toxic reaction. Professor Florey believes that the purer the penicillin, the less toxic it is. He found that mice, receiving 40 units per mg., had a severe reaction ; those injected with 250 to 350 units per mg. showed none. However, doses over 5,000 units intrathecally can give rise to headache, emesis and increased intracranial pressure in normal individuals.

The general effect on patients receiving penicillin follows a fairly characteristic pattern. The improvement is gradual and is neither sudden, rapid or dramatic :—

1. Temperature falls by lysis.

2. Appetite increases.

3. There is a steady gradual rise in r.b.c. and Hb.

4. Less need for opiates.

5. The bone lesions in patients treated for acute osteomyelitis undergo interesting changes. At first there is more bone rarefaction, followed later by bone deposition. There is either absorption of sequestra or else the latter, once sterile, are used as a scaffolding for osteoblastic activity. However, to the uninitiated, the early X-ray picture might readily mislead one to the conclusion that the bone infection had worsened.

CLINICAL APPLICATION.

There are certain criteria governing penicillin therapy which we must observe :—

1. The organism must be sensitive.

2. There must preferably be no other form of therapy.

3. Although the supply is limited, give liberal doses at first to prevent organisms from developing a resistance. Therefore it does not pay to be parsimonious.

4. There must be adequate access to the affected part.

5. Dosage governed by bacteriostasis. One cannot be too dogmatic about the actual dose. In general, it is better to err on the generous side ; then, if necessary, one may shade down and, in that manner, one can avoid the possible development of

penicillin-fast strains. There is some evidence, both clinical and laboratory, which suggests that complete bacteriostasis may not be necessary throughout the whole interval between doses. For instance, Gardner has demonstrated altered bacterial morphology, in concentrations far less than that necessary for bacteriostasis, in a given strain. We have treated one or two cases in which bacteriostasis beyond two hours was unobtainable, yet clinical cure of the disease was effected.

For severe streptococcic infections : 10–20,000 units Q.3 h. to Q.4 h. intramuscularly.

For severe staphylococcic infections : 15–30,000 units Q.3 h. intramuscularly.

For severe clostridial infections : 40–50,000 units Q.3 h. by intravenous drip or intravenous injection Q.1 h. or Q.2 h. In mice, repeated doses gave better results against Cl. Welchii than single large doses. McIntosh and Selbie report that better results are obtained against Cl. Welchii infections in mice if antitoxin and penicillin are used together. They also claim that sulfathiazole is more effective against Cl. septicum in mice. Local applications of penicillin are also necessary, and some observers believe this is the most important method of attack in dealing with gas gangrene. It is well to introduce an additional 50,000 units intravenously daily for the first two or three days (covering a period of six to eight hours) in the severe staphylococcus or streptococcus infections.

6 Limitation of fluids : 2,000 to 2,500 c.c. daily.

7. Duration of treatment.—Acute streptococcus : Seven to ten days. Acute staphylococcus : longer. Should continue for a week after the temperature has reached a normal level. Chronic infections : three weeks' minimum. Professor Florey and Dr. Florey believe by that time the body forces are sufficiently strong to handle the infection themselves. We can also be guided by the clinical course of the patient : progress, behaviour of the local lesion, especially the character of the exudate and microscopic study of the wound smear ; w.b.c. and diff., E.S.R., r.b.c. and Hb ; blood culture ; wound culture. *Causes of failure :*

Inadequate dosage—trying to save ;

Inactivation of penicillin—heat, alcohol in syringe, H_2O_2 in wound ;

Resistant strains ;

Too large sequestra ;

Large undrained abscesses ;

Extensive slough.

Professor Florey states : " The objective in treatment should be the maintenance of a sufficient concentration of penicillin in the blood to inhibit completely the growth of the infective organism (therefore the importance of testing for inhibition at the end of each hour up to time of next dose). Because it is bacteriostatic, and not bactericidal, reliance must be placed upon the body defences, both humoral and cellular, to destroy bacteria in a lesion, whilst the penicillin prevents their multiplication." The dosage strength might be of some practical interest to you :—

Intramuscular: 5,000 units per c.c. ; often 10,000 per c.c. (Deltoid or gluteus).

Intrathecal : 5,000 units per 2 to 4 or 5 c.c. (Make sure there is no block, otherwise ventricular route).

Intravenous : If given as single dose : 1,000 units per 5 c.c. to 10 c.c.
If a drip : 25,000 to 50,000 units per 500 c.c. to 1,000 c.c.

(Give in arms. Infarcts reported in connection with intravenous drips into leg veins.)

Oral, duodenal, rectal : not employed.

Local application : varies considerably ; sodium salt 250 units to 1,000 units per c.c.

Burns : 150 to 250 units per grm. of " cream."

Wounds (prophylactic) : 1,000 units to 5,000 units per c.c. ; or per 0.1 to 0.2 grm. of dried plasma (Colonel Cutler); or per grm. of sulfanilamide powder.

Local infections : 250 to 500 units per c.c. or grm. b.i.d.

If we had an inexhaustible supply of penicillin, the indications for therapy would be as follows :—

1. Local staphylococcic infections, particularly osteomyelitis.
2. Cavernous sinus thrombosis.
3. Bacteremia : especially staphylococcus and streptococcus.
4. Gangrene : clostridia (worth trying).
5. Sulfa-resistant gonococcal urethritis.
6. Staphylococcus pneumonia, empyema and meningitis.
7. Sulfa-resistant pneumococcus or streptococcus pneumonia, empyema and meningitis, as well as sulfa-resistant meningococcus meningitis.
8. Local application in—
   (*a*) certain war wounds : (Professor Florey in North Africa, Colonel Cutler in East Anglia).
   (*b*) certain head wounds : (Brigadier Cairns in North Africa).
   (*c*) certain local infections : (Dr. Florey).
   (*d*) certain skin lesions ; sycosis barbæ, impetigo, furunculosis.
   (*e*) infected burns : (Professor Colebrook, Bodenham).
   (*f*) certain eye lesions.
9. Lues (Syphilis) : 800,000 units one week. Four cases. (Mahoney in U.S.)

(*To be continued*)

To My Brother

Killed 1941 (*R.A.F.*).

HARK ! the guns are thundering
"Awake and come to war."
I hear your comrades calling,
"Awake and fight once more."

Oh ! my belovèd brother,
I would that you were here,
Among the quick and living,
Or I your arms could bear.

In England they'll not train us,
To Russia I cannot go ;
I can but wait and wonder,
Nor ever strike one blow.

Oh ! why was I born a woman ?
'Tis far the harder part
To nurse the sick and suffering
With murder in one's heart !

"Patience, my fiery sister ;
You, too, can do your share.
You say your lot is harder—
'Tis nobler then to bear.

The lads require your Faith in them,
Show it in every way ;
Keep to your path of Duty—
Ever her laws obey."

DEVAN.

The Nurses' Home,
Guy's Hospital.

Correspondence

MEDICAL AND DENTAL TRAINING.

To the Editor of the GAZETTE.

SIR,—In your "Passim" of June 10th you brought to light what I believe to be a very serious deficiency in the medical and dental trainings of the London hospitals—that of lack of cultural development alongside scientific. The importance of a broad education, whether at school or at the university, cannot be over-emphasised, and it is a great failing of the present system of medical and dental training that specialisation comes too early in life. At the immediate moment this deplorable tendency is, no doubt, in some degree the result of the War, but, nevertheless, specialisation is now taking place at an earlier age than it did in our parents' day, and we are, I think, the losers thereby.

What action, however, is to be taken once specialisation has commenced, to ensure that the qualified practitioner has a balanced outlook? I would suggest that the preclinical period is the time when contact with the humanities is most inclined to be lost, for then there are no associations with patients and their individual personalities, and so much contact with corpses and physiological preparations. At this stage, therefore, efforts must be made to keep up and encourage the general education which is promised in all schools after the War. It would seem that one of the most efficient methods of doing this would be to institute hostels in London, which would board all types of students, studying all types of subjects. These hostels should then be encouraged as places of residence rather than "digs," and would in some degree simulate the colleges of Oxford and Cambridge.

In "Passim" you suggest that lectures "on a purely voluntary basis" should take place on "such subjects as the History of Science, Modern History and Current Affairs." Might I add to this list Types of Government, Politics, Literature, Ancient Philosophy and, most important of all, a study of foreign countries, with an attempt to understand their people and their problems. And, while agreeing that compulsion, except where absolutely essential, is to be avoided at all costs, yet when considering the enormous influence a doctor has on many people's lives, and how they are looked up to as men of intelligence and balanced views, is it wrong to suggest that pressure be applied so that each student attends a course of at least one of these ancillary lectures?

I hope that in the reconstruction after the War a very serious attempt will be made to correct these deficiencies in the present method of medical and dental education, and so ensure that all who leave the Hospital are qualified, not only in their profession, but also as beholds their position in society.

I am, etc.,

Guy's Hospital, S.E.1. S. P. JOHNS.

Sport

Cricket

GUY'S *v.* MIDDLESEX HOSPITAL.

(Played at H.O.P. on June 3rd.)

Result: Guy's won by two wickets. Score: Middlesex Hospital, 97; Guy's, 103 for eight wickets.

Middlesex Hospital won the toss and elected to bat. Their start was disastrous, three of their wickets falling with only 11 runs on the board. Trist and Carton-Kelly played further havoc with the opposing batsmen until the score read 25 for seven wickets. At this stage Webb joined Rifaat to nurse the score to 70 before being caught. Rifaat obtained 43 of his side's runs, his innings being unfinished when the side were all out for 97; it should, perhaps, be mentioned that on two occasions he struck the ball full toss to a fielder, and each time the ball passed rapidly through the fielder's hands to the turf beneath.

Suffice it to say, that Guy's made the runs. Garland, in a hurry, scored 21; Boyd, unluckily stumped, made 17; and Graham got 23, alternately scoring with fine off-drives and strokes more suited to our Far Eastern Ally.

Team.—E. G. Murphy, D. R. S. Saunders, R. G. L. Brittain, G. W. Garland, I. A. H. Munro, D. C. Boyd, L. D. Carton-Kelly, G. Thompson, D. J. Sheerboom, A. E. Trist, E. W. Graham.

Swimming Club

At a meeting in February B. H. Pickard was elected captain and R. G. Iliffe elected hon. secretary.

The first match was against Epsom College, which we won by a wide margin. The most notable event was the 100 yards free-style by D. J. Gray, who swam the distance in 54.5 sec., one of the fastest times in the country to-day.

On June 7th we went to Bishop Stortford College for another enjoyable match, which we again won comfortably.

The team consisted of:—B. H. Pickard, R. G. Iliffe, D. J. Gray, B. M. Gray, G. R. Waller, J. Fine, H. Keeling, J. E. H. Lahaise, R.A. Dean and D. Walker.

Sailing Club

This year marks the twentieth anniversary of the United Hospitals Sailing Club, of which Guy's was an original member. As a fitting recognition of its virility after all these years, and during war-time, a season of inter-hospital sailing matches began early in April. The course sailed is between Hammersmith Bridge and Barnes Bridge, and takes, roughly, one hour to sail over in a fair breeze.

To date six matches have been sailed, Guy's having competed in three of these:—

April 12th.

Guy's (D. J. Reid); London; St. Thomas'; St. Batholomew's.

It so happened that for the first race Bart.'s was the only hospital to send a crew of two, as required by the rules. All boats got away to a good start and kept well together up to the mark. On the return the Guy's boat made full use of the light south-westerly wind and crept back along the north bank to win by 3 mins. Bart.'s and St. Thomas' were second and third, whilst London were quite a distance behind, being fourth.

April 26th.

Guy's (D. J. Reid, C. M. M. Jenkins); Bart.'s; Charing Cross; and Royal Dental.

The wind was again very light, barely sufficient to take the boats up to the mark. Guy's and Charing Cross decided to anchor before being swept under Barnes Bridge, but, unfortunately, had to break the rules by rowing out of the way of some tugs. Bart.'s, who came to the buoy last, did not anchor, but managed by skilled sailing to hold her own against the current. Even so, Jenkins managed to bring Guy's back second, only a few seconds behind Bart.'s, although only one point was obtained, as the boat had been disqualified.

June 6th.

Guy's (D. J. Reid, G. Elphicke); Royal Free; Westminster; Charing Cross; and Royal Dental.

All boats crossed the line together, the Royal Free soon drawing ahead. They held their supremacy until they reached the buoy, when Guy's and Charing Cross turned inside them. Reid chose to make short tacks out of the tide in the south bank, whilst all the others stood out across the river. Westminster was unable to stem the tide and rapidly fell back. Royal Free soon following them. Guy's and Charing Cross were then left to fight it out; and a long luffing match ensued, in which Guy's obtained the upper hand, winning by 9 secs.

The following table gives the scores to date:—

	No. of races	*Points*
Guy's	3	8
Bart.'s	3	17
Royal Free	3	10
London	3	7
Mary's	3	nil
Thomas'	3	13
U.C.H.	3	13
Westminster	2	3
Middlesex	2	12
Charing Cross	3	5
Royal Dental	3	5
King's	2	7

Hospital Information, etc.

Guy's Hospital Ladies' Association

The well-attended forty-seventh annual general meeting of the Guy's Hospital Ladies' Association was held in the Nurses' Home on Friday, June 9th, 1944, with Colonel Eric Waley, O.B.E., in the chair. Mr. John E. Humphery, Chairman of the Hospital, together with the Matron, attended.

The sum of £380 was presented to the Hospital towards the endowment of cots and 2,885 garments for the use of the patients. The Chairman and Matron, in thanking the Members, both stressed the importance of the work and personal interest that the Members of the Ladies' Association rendered to the Hospital.

The resignation of Mrs. A. Bulleid, Hon. Secretary for the past three years, was received with regret. Mrs. A. D. Marston was welcomed as the new Secretary, together with Mrs. Northall-Laurie, who has generously undertaken to assist the Committee. Mrs. Sanders has kindly consented to continue to act as Hon. Treasurer.

A room in the Hospital has been put at the disposal of the Ladies' Association, where old and new Members will be welcome. Mrs. Marston, 80, Harley House, N.W.1, the Hon. Secretary, will be pleased to send details of membership and answer enquiries regarding the activities of the Association.

The Services

Prisoner of War.

Temp. Major H. M. S. G. Beadnell, R.A.M.C., previously reported missing is now reported prisoner of war.

M. K. Berman, L.D.S., of Johannesburg, is now reported prisoner of war in Switzerland.

Birthday Honours

C.B. (Military Division).

Major-General G. A. Blake, M.B., K.H.S., late R.A.M.C.

C.B.E. (Military Division).

Lieut.-Col. (Temp. Col. local Brig.) Grant Massie, M.S., F.R.C.S., R.A.M.C.

O.B.E. (Military Division).

Lieut.-Col. H. J. Bensted, R.A.M.C., M.C., M.R.C.S.

Change of Address

D. S. Hayton-Williams, Capt., R.A.M.C., No. 3 Maxillo Facial Surgical Unit, Indian Command.

Deaths

MAY.—On June 12th, 1944, following an operation in Reading, William Norman May, M.D., of the White House, Sonning, aged sixty-two years.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

WE hope that many people have taken the opportunity to visit the models and plans of the proposed new buildings which are to take the place of many of the damaged ones. We know that feelings will be very mixed and arguments heated, for we remember the discussions which took place in these columns on this very subject some years back, but now that people can see with their own eyes the suggestions will be helped to be more constructive.

As we studied these plans and tried to imagine in our mind's eye how they would appear in reality we could not but reflect upon a comparison of ideas which the models occasioned. The two styles of building, so apparently different, seemed to represent a contrast which is as old as history and is seen in many spheres of life, a contrast between what might be termed the traditional or historical approach to Medicine and an approach which we might call the rational.

The new buildings so totally dissimilar to the old ones (this must break the hearts of many old associates of the Hospital before it became a casualty) seemed to be symbolic of the rational or, shall we say, utilitarian outlook in Medicine. This rational point of view is the keynote to the modern approach to scientific Medicine. We see it on every hand in White Papers, B.M.A. schemes, M.R.C. pamphlets, etc., for now that science has come to be accepted as an integral and vital part in the world's economy, it can afford to adopt this attitude in order to extend its powers.

But no system of thought ever carried any authority without a living tradition, and we perhaps anticipate the thoughts of those who are concerned for the future of scientific medicine if we make the statement for them that these new buildings represent a frame of mind which has scant respect for medical tradition.

Yet we submit that, paradoxically enough, this point of view is precisely what these buildings do not represent. They represent, in fact, a reasonable view of tradition which sees in this departure a living spirit taking no account of the solid, yet hollow, structures which too easily pass in the minds of some as a preservation of the old order.

The traditional and historical approach to any study is of first importance, as can readily be seen in many of our national institutions, yet how foolish we should be if we allowed this vital factor to depend upon the shape of a pillar or upon the grime which drapes its sculptured figures. Rather should we let it be born naturally from the living spirit of tradition which is handed on from generation to generation than let it be stifled by the poison-ivy which grows so readily upon the grimy walls.

Tradition is a noble and valuable asset to scientific Medicine since by it we learn to respect the labours of those who helped to lay the foundations, and by it we are helped to follow their ways of thought. But we maintain that these very men should be the first to appreciate that Medicine is no static thing, but one which goes from strength to strength and will not be shackled by outmoded ways of thinking or misplaced sentiments.

WE should like to make further apologies for the reduced number of pages you have before you but the transport situation has again delayed our paper supplies and may continue to do so for some little time to come.

Obituary

GEORGE EMILE YARDLEY.

THE news of George Yardley's death has been a great shock to his many friends at Guy's, and our feeling of sympathy must go out to his widow and two small sons.

George Yardley was born in Paris and came to England in 1918, when he went to Caldicott Preparatory School. From 1923–1927 he was at The Leys School, Cambridge. He read Law at Cambridge from 1927–30 and went to Harvard for a year afterwards. On his return to this country he decided to take up medicine and came to Guy's. He qualified in January, 1937, and was a clinical, house-surgeon to Mr. Brock, Out-patient officer and house physician to the late Dr. Poulton. On leaving Guy's he went to Harefield Sanatorium for six months and, after that, joined two old Guy's men in their practice in Windsor. During the short time he spent in this practice he became extremely popular with his patients. He was commissioned Lieut., R.A.M.C., in January, 1941, and after two years' service at home went to North Africa and later to Italy. He was wounded at Cassino on May 16th and died later that day in hospital. He was buried in the British Hospital at Naples.

George was a quiet and very modest person. He was a born doctor and extremely successful with his patients. Though he had to work extremely hard in his practice he always found time to improve his knowledge of subjects other than his profession. He was widely read and knew both English and French contemporary literature intimately.

A number of us will always remember his great performance as an old negro woman in the last "Niggers."

Some Notes on Penicillin

By R. N. SCHULLINGER Lieut.-Col. M.C., U.S. Army

(Concluded)

Some of the clinical results reported in literature should be called to your attention :—

I. Florey and Florey. *Lancet*, March 27th, 1943. Here we note recoveries with osteomyelitis, cavernous sinus thrombosis, streptococcus meningitis, staphylococcus pyemia, osteomyelitis with pyemia ; but streptococcus viridans endocarditis, improvement during month of therapy, died three weeks after cessation of therapy. *Local*: Mastoiditis, eye infections (blepharitis, acute conjunctivitis, gonococcal infections, ophthalmia neonatorum, chronic conjunctivitis, dacryocystitis), wound sinuses, infected fingers, empyemata, wounds, carbuncles and dermatitis.

II. In a later series of hand infections (*Lancet*, January 15th, 1944) treated locally, with a corresponding number of controls, Dr. Florey was impressed by the following :—

1. Earlier relief of pain.
2. Less discharge ; early disappearance of pus and bacteria.
3. Less swelling, more rapid diminution.
4. Healing in half the time of controls ; less granulation tissue.
5. Greater restoration of function.
6. Saving of man-hour working time.

Most of these cases were abscesses, felons, closed space and web space infections, paronychia, suppurative tenosynovitis, and septic lacerations of the hands. Tendons remained viable in the cases treated early with penicillin. In controls, death of tendon occurred in nine out of fourteen cases. These hundred cases were treated with only 500,000 units of penicillin.

III. Keefer, Blake, Marshall, Lockwood and Wood :—

1. Ninety-one cases staphylococcus aureus bacteremia. 60 per cent. recovery ; 30 per cent. no change.

2. One hundred and thirty-seven cases of staphylococcus aureus infections without bacteremia. 80 per cent. recovery, 12 per cent. no change (osteomyelitis, empyema, burns, and skin and subcutaneous infections).

3. Thirty-three sulfa resistant streptococcus infections (exclusive of bacterial endocarditis), seventeen (50 per cent.) recovered or improved; four, no change; and twelve died (36 per cent.).

4. Seventy-six pneumococcal infections. Except for pneumonias, did rather poorly. Only a third of pneumococcus meningitis recovered. One case of pneumococcus endocarditis recovered.

5. One hundred and twenty-nine G.C. sulfa resistant urethritis. 125 cured.

6. Five cases meningococcus meningitis. Four recoveries. Fatal case had no intrathecal therapy.

7. Seventeen cases subacute bacterial endocarditis. Ten showed no change, three improved only temporarily.

No effect on atypical pneumonia, monilia, putrid lung abscess, actinomycosis.

IV. Colebrook, (*Lancet*, May 15th, 1943.) Infected burns. He applied penicillin cream every two days for three applications and then skin grafts. His results have been most successful.

V. Flight-Surgeon Bodenham, D.C. (*Lancet*, December 11th, 1943). Treatment of deep burns and surface wounds with very satisfactory results. He also described local penicillin therapy in various types of infected wounds, with varying degrees of success :—

1. Surface wounds.
2. Gutter wounds.
3. Sinuses.
4. Dependent cavities.
5. Inverted cavities.
6. Multi-loculated cavities.

Nos. 5 and 6 did not respond particularly well.

VI. Florey: Report on North African experiences. Professor Florey's investigations in North Africa are extremely interesting and significant. Working chiefly with Lieut.-Colonels Fraser, Jeffrey, Button, Jolly and d'Abreau, and Majors McLennan and Scott Thomson, he studied various types of war wounds. The first group consisted of chronic septic flesh wounds and compound fractures three to ten weeks old. In all, the infection was a polybacterial one, and the wounds contained chiefly staphylococcus aureus, streptococcus, diphtheroids, B. coli, proteus and pyocyaneus. The flesh wounds responded rapidly to local treatment and, as the penicillin took hold, the pyogens disappeared. However, there were four resistant strains of staphylococcus. Obviously local treatment in the compound fractured wounds was inadequate, due to inaccessibility of the penicillin to reach deep cavities, necrotic tissue and sequestra. Parenteral penicillin therapy was therefore instituted, together with certain operative revision of the wounds, such as removal of large sequestra, slough and possibly foreign bodies. Even so, there were only a few recoveries. The compound fractured femurs presented the worst problems. It soon became apparent that treatment of large numbers of such cases was impractical because of the limited supply of penicillin. The next step therefore, was to devote attention to more recent wounds in the hope of preventing the development of the chronic septic ones just described.

Accordingly, recent soft tissue wounds (three to twelve days old) were treated at certain forward base hospitals. These cases had received initial cleansing, simple débridement, local sulfanilamide powder, vaseline gauze and snug dressings at the C.C.S. or F.S.U. *En route* to the forward base hospitals the majority were probably given oral sulfonamides. On arrival at the hospital most of the wounds appeared dirty and clinically infected or purulent.; 57 per cent. disclosed bacterial growth. In some the procedure was débridement, insufflation of calcium penicillin powder (2,000 units per grm. of sulfanilamide powder) into the wound, suture of the wound, and instillation of calcium penicillin solution (250 units per c.c. saline) into the wound (by way of one or more small soft rubber tubes inserted to the wound depths at time of operation), twice daily for four or five days, introducing about 3 c.c. into each tube. Other wounds, particularly when associated with surrounding swelling and œdema, were treated with preliminary cleansing and insufflation of penicillin powder for three days, followed by débridement, suture and local instillations as previously described. Still others, especially the later ones in the series, were débrided, irrigated, insufflated and sutured *without* subsequent instillations. The wounds, which were instilled with penicillin solution for several days, usually discharged a salmon pink pus, rich in healthy leucocytes and disclosing coliform bacilli on culture. This discharge soon disappeared and the tubes were removed on, approximately, the fifth day, and sutures taken out on the tenth to fifteenth day. There were some variations in wound behaviour, but in *none* was there any adverse local or general reaction. The results

were most encouraging: 60 per cent. healed by first intention, 35 per cent. underwent a subtotal union, and only 5 per cent. broke down and reopened. The subtotal group usually had a slight separation, disclosing a healthy, granulating surface which proceeded to heal rapidly, almost as quickly as those with primary union. The most difficult types to handle were deep buttock wounds and amputation stumps. In the first two groups the wounds were firm, healed linear scars at the end of three weeks, and by the sixth week the patients were ready for return to duty. Such treatment reduced the time of wound healing by three to six weeks, minimised the amount of scar tissue formation, and obviously favoured more rapid restoration of function. It halved the soldier's duration of disability.

Finally, it was decided to treat a series of freshly wounded casualties with penicillin, instead of sulfanilamide, at the C.C.S. and F.S.U. The average time between wounding and treatment at the C.C.S. or F.S.U. was thirty hours. The area was shaved, the skin cleansed with soap and water, the wound thoroughly irrigated with saline, and then very gently "trimmed," with little or no excision of skin; removal of foreign bodies, débris, loose tissue tags and shreds of muscle, incision (if necessary) of skin and fascia to relieve tissue tension and allow drainage—in other words, a conservative tissue-respecting débridement as prescribed by Major-General Ogilvie. Calcium penicillin-sulfanilamide powder (5,000 units per grm.) was then generously applied to all parts of the wound, vaseline gauze gently and loosely inserted and secure dressings applied. They were then sent to the forward base hospitals (average time of travel was five days) and upon arrival the wounds appeared cleaner than the previous group, treated with sulfanilamide in the forward area. Only 26 per cent. revealed bacterial growth (57 per cent. in the sulfanilamide treated group). At the base hospital they were treated in the same manner as the original series of soft tissue wounds—namely, revision of the wound, local penicillin therapy and closure. Sixty-seven per cent. healed by primary union (60 per cent. in the previous series), 30 per cent. exhibited subtotal or partial union (35 per cent. with the other series) and 3 per cent. were failures (5 per cent. in the first series). The results were therefore most encouraging in that there was a distinctly higher percentage of healing by first intention and a total failure of only 3 per cent.

The compound fractures were studied at the same time and in the same manner as the two series of soft tissue wounds. The aim was to convert an open fracture into a closed one, as quickly as possible, in an effort to prevent the formation of a chronic septic wound, similar to that which Professor Florey first studied on his arrival in Africa. The first group of compound fractures consisted of those treated with sulfanilamide and vaseline gauze at the C.C.S. or F.S.U. Their average time of arrival was five to fourteen days after leaving the forward area. Most of these wounds harboured bacteria. Nevertheless, they were treated in the same manner as the previously described simple soft tissue wounds—namely, by revision, trimming of loose tissue tags and skin edges, removal of any foreign material, irrigation, local application of penicillin, and suture of the wound. However, it was impossible to obtain complete closure in some of them. In addition, parenteral penicillin was administered for approximately five days, using 15,000 units every three hours—intramuscularly, as a rule. Half of these cases healed by first intention and another 30 per cent. (including those impossible to close completely) underwent a subtotal union. These results are nearly as good as those obtained in the corresponding series of soft tissue wounds. The importance of successful closure of compound fracture wounds in preventing osteomyelitis, and thus favouring bony union is obvious. The failures were due, in large measure, to insufficient parenteral penicillin in treating the compound fractures of the long bones in the lower extremity.

Lastly, the compound fractures treated with gentle débridement, local penicillin, vaseline packing and immobilisation at the C.C.S. and F.S.U. had even better results than the previous group; on arrival at the forward base hospital, the wounds looked cleaner than the sulfanilamide treated cases. Following treatment at the base hospital, including local and parenteral penicillin therapy, these wounds healed by first intention (44 per cent.) or by subtotal union (44 per cent.) in all but one case. Total series of nine cases.

The results of these studies are exceedingly significant and far-reaching. With adequate supplies of penicillin, therapy of soft tissues wounds (these made up half the total battle casualties) in the forward areas should consist of cleansing, gentle "trimming" débridement with minimal excision of skin, irrigation, local application of penicillin, loose insertion of vaseline gauze, snug dressings and splinting when indicated. The treatment of the compound fractures should be conducted along similar lines. As soon as feasible, both types of case should be sent to the forward base hospitals,

where more definitive therapy, as already described, can be instituted without necessity of further transference of the patient. It was the general opinion of the surgeons, connected with this penicillin study, that wounds should practically *never* be closed in the forward areas, but that suture at the forward base hospitals should be effected within ten days to two weeks after wounding. There are several reasons for avoiding further delay in closure : the incidence of secondary streptococcal infection rises rather sharply at the end of two weeks, frequent dressings and transfers to other hospitals are trying for the patient, and the danger of secondary hæmorrhage becomes a very real one. The œdematous swollen wounds should receive daily dressings and penicillin applications, followed by suture when the œdema subsides. The soldier with a compound fracture, heretofore considered a probable loss from a military standpoint, can now be salvaged for return to full or limited duty. The local management of the wound (débridement and penicillin application) requires no modification of existing methods of immobilisation of the fracture. Professor Florey believes that in the future parenteral penicillin therapy should be continued for five days (500,000 units) in compound fractures of the upper extremity long bones, ten days (1,000,000 units) for compound fractures of the tibia and femur, and three days (300,000 units) for lesser compound fractures. This study has pointed the way towards proper handling and treatment of war-time soft tissue wounds and compound fractures.

VII. Brigadier Cairns. Head wounds of three days or older were chosen (earlier wounds well treated.—Eden's report) :—

(*a*) Twenty-three penetrating wounds three to twelve days old ; thirteen grossly purulent ; nineteen had gram positive pyogens. They were all excised and débrided, closed (except one) and a fine rubber tube was inserted through stab wound into brain cavity. Ca. penicillin 250 units per c.c. instilled twice daily for four to five days. Average total dosage, 15,000 units. Wound aspirated before each subsequent injection. In all but two the organisms disappeared after second day ; three deaths ; of the twenty that recovered almost all wounds healed by first intention.

(*b*) Seventeen non-penetrating wounds one and a half to sixteen days old ; treated in same manner. All but two healed satisfactorily. However, bacteria persisted longer, probably because some infected bone may have been left.

VIII. Penicillin therapy of surgical infections in U.S. Army. (Small series.) Major Champ Lyons, Surgeon-General's Office and O.S.R.D. :—

Bacteremia : six of nine staphylococcus cases recovered. Staphylococcus without bacteremia : 87 per cent. recovery.

Chronic osteomyelitis : good surgery as well as penicillin therapy.

Three of four b-hem. streptococcus cases recovered.

Streptococcus without bacteremia : very satisfactory ; no deaths.

Streptococcus and staphylococcus : six out of eight cases responded well.

Putrid lung abscess : no improvement.

But more important was his study of chronic infection in compound gunshot fractures. Forty-five cases :—

1. Nutritional depletion : weight loss, asthenia, muscle atrophy, anorexia, anæmia. Interstitial fluid volume : 4–7 L. too great for patient's standard weight. Reduction of 1,500 to 2,000 c.c. in blood volume. Therefore certain amount of tissue plethora. Total Hb. and tota' protein are low. Thus, minor blood loss at operation may be dangerous and lead to shock.

These cases received 130 grm. to 150 grm. protein a day. Also 500 c.c. plasma, 500 c.c. blood on day before day of operation, and first day post-operation, and thereafter once or twice a week until Hb. was 15–16 grm. per cent.

2. Bacterial study. Four main types :—

(*a*) Putrid : 74 per cent. of cases. Proteolytic clostridia, microaerophilic and non-hæm. anærobic streptococcus, and proteus. They attack dead tissue, devitalised bone fragments, ischemic or avascular muscle and blood clot. Clostridia consist of sporogenes bifermentens and tetanomorphum group.

(*b*) Staphylococcus : 65 per cent. of cases (only four cases *pure*).

(*c*) b-hæm streptococcus : 33 per cent. of cases. No single case of pure culture.

(*d*) Pyocyaneus : 26 per cent. *Never* pure.

3. Selection of cases for surgical treatment. Removal of sequestra and foreign bodies (metallic, clothing, concrete, etc.) :—

Group I.—Latent infection with *no* nutritional disturbance ; no penicillin.

Group II.—Latent infection *with* nutritional disturbance ; RX : period of diet and transfusions. Then operate. With or without penicillin (optional).

Group III. Acute infection with *no* nutritional depletion. Stat. treatment with penicillin and operation.

Group IV. Acute infection *with* nutritional depletion consists of majority of patients. These cases underwent a preliminary period of treatment with special high protein diet, transfusions, and sometimes parenteral penicillin, for a period of three to seven days. Blood and plasma were then given on the day preceding operation, the day of operation and the day following operation. Parenteral penicillin was continued for approximately a week. After the first wound dressing, usually on the seventh day, local penicillin therapy was instituted.

4. Results : 88 per cent. (forty cases) improved or recovered. Thirty-four of these forty had sequestrectomy ; of six that did *not* two had recurrences. No operation in five failures. No deaths.

IX. Special penicillin study on fresh battle wounds is being conducted by Colonel Cutler, Chief Surgical Consultant to the U.S. Forces. The results will be published in July.

X. Gangrene. Reports of recovery from clostridial infections with the aid of surgery, serum, and penicillin are now appearing in the literature. Colonel Cutler, U.S. Army, reported three survivals at the section meeting of Experimental Medicine and Therapeutics, Royal Society of Medicine, on November 9th, 1943. In the North African report, Professor Florey described seven cases of gangrene with four recoveries. Recently the survival of a seven-year-old girl, with severe gangrene of the arm, has been published in the Journal of the A.M.A. Liberal amounts of penicillin should be applied to the wound, and large doses must be given intravenously, or intramuscularly, or by both routes, although there is some doubt about the efficacy of parenteral therapy in such infections.

XI. An account of survival of seven patients with subacute bacterial endocarditis, treated by heparin and penicillin, is recorded in the Journal of the A.M.A. Five had a streptococcus viridans bacteremia, one patient revealed a hæmolytic streptococcus, and another disclosed a pneumococcus type 27 in the bloodstream. Heretofore, no cases with streptococcus viridans endocarditis had responded successfully to penicillin ; at best there had been only temporary improvement. These seven recent cases received very large doses of penicillin and several underwent two or three courses of penicillin therapy. The follow-up is relatively short, and it will be interesting to learn how these patients are faring at the end of five and ten years.

XII. Our own series of cases, though small, have been most encouraging. They comprise such conditions as osteomyelitis, wound infections, severe furunculosis, and one case of hæmolytic streptococcus bacteremia. There have been three failures. A more detailed report will appear in July.

XIII. The treatment of sulfa-resistant gonococcal urethritis with penicillin has been extremely successful. A comprehensive study of this particular problem has been made by Major Robinson, U.S. Army, Consultant in Urology, and the results of his findings will be published in July.

CONCLUSION.

Penicillin is a potent bacteriostatic agent against certain organisms if it is used intelligently and in suitable selected cases.

It should not be employed haphazardly in any type of infection or where the infective agent is unknown. One exception : early overwhelming infection. The dosage should be liberal at the inception of treatment in order to prevent penicillin-fast strains. Therefore " strike hard " at the very beginning.

Treatment should be carefully controlled by sensitivity and bacteriostatic tests at sufficiently frequent intervals. Other laboratory data will be necessary according to the requirements of each individual case.

Treat your cases early and not when they are in the " coffin " stage.

The supply of penicillin is still limited, so let us not be wasteful. Priority should be given to those whose lives are jeopardised or threatened with permanent severe disability. For this reason the November issue of the *U.S. Army Medical Bulletin* recommends restriction of penicillin administration to four categories :—

1. Life endangering infections caused by staphylococcus, streptococcus or pneumococcus.
2. Staphylococcus, streptococcus, pneumococcus or sulfa-resistant meningococcus meningitis.

3. Severe infections, both acute and chronic, which have not responded to other methods.
4. Gas gangrene.

Much still remains to be learned about the physiology of penicillin.

Let us not regard penicillin as the miraculous cure-all for infections, and neglect or overlook the sound fundamental principles of surgical treatment which we have learned from our wise teachers and by our own experience.

Therefore, unless the therapy of penicillin be intelligently conducted, with sound judgment and critique, it will fall rapidly into disrepute. We must not be carried away or misled by our own enthusiasm.

Thanks are herewith acknowledged to Colonel E. C. Cutler, Chief Surgical Consultant, European Theatre of Operations; and to Colonel P. M. Crawford, Commanding Officer of the 2nd General Hospital, for permission to accept Sir Arthur Hurst's kind invitation to address the staff and students at Guy's Hospital.

REFERENCES.

Fleming, A. *Brit. Journ. Exp. Path.* 10, 226. 1929.
———. *Journ. Path. Bact.* 35, 831. 1932.
Clutterbuck, P. W., Lovell, R., and Raistrick, H. *Biochem. Journ.* 26, 1907. 1932.
Abraham, E. P., Chain, E., Fletcher, C. M., Gardner, A. D., Heatley, N.G., Jennings, M. A. and Florey, H. W. *Lancet*, 2, 177. 1941.
Powell, H. M., and Jamieson, W. A. *Proc. Soc. Exp. Biol. & Med.*, 49, 387. 1942.
McKee, C. M., and Rake, G. *Idem.*, 51, 275. 1942.
Abraham, E. P., and Chain, E. *Brit. Journ. Exp. Path.*, 23, 8. 1942.
Florey, H. W., and Jennings, M. A. *Idem.*, 23, 120. 1942.
Abraham, E. P., and Chain, E. *Brit. Journ. Exp. Path.*, 23, 103. 1942.
Florey, M. E., and Florey, H. W. *Lancet*, 1, 367. 1943.
Clark, A. M., Colebrook, L., Gibson, T., and Thomason, M. L. *Lancet*, 1, 605. 1943.
Herrell, W. E., Cook, E. N., and Thompson. *Journ. A.M.A.*, 122, 289. 1943.
Keefer, C. S., Blake, F. G., Marshall, E. K., Jr., Lockwood, J. S., and Wood, W. B., Jr. *Journ. A.M.A.*, 122, 1217. 1943.
Rammelkamp, C. H., and Keefer, C. S. *Journ. C.I.* 22, 425. 1943.
——— and ———. *Journ. C.I.*, 22, 649. 1943.
Hamre, D. M., Rake, G., McKee, C. M., and MacPhillamy, H. B. *Am. Journ. M. Sc.*, 206, 642. 1943.
Bodenham, D. C. *Lancet*, 2, 725. 1943.
Hac, L. R., and Hubert, A. C. *Proc. Soc. Exp. Biol. & Med.* 53, 61. 1943.
McKee, C. M., and Houck, C. L. *Idem.*, 53, 33. 1943.
McIntosh, J., and Selbie, F. R. *Lancet*, 1, 793. 1943.
Pilcher, C., and Meacham, W. F. *Journ. A.M.A.*, 123, 330. 1943.
Challinor, S. W., and MacNaughton, J. *Journ. Bact. & Path.*, 55, 541. 1943.
Likely, D. S., and Sivirsky, M. Y. *Journ. A.M.A.*, 123, 956. 1943.
McKee, C. M., and Houck, C. L. *Fed. Proc.*, 2, 100. 1943.
Foster, J. W., and Woodruff, H. B. *Journ. Bact.*, 46, 187. 1943.
Lyons, Champ. *Journ. A.M.A.*, 123, 1007. 1943.
Pulvertaft, R. J. V. *Lancet*, 2, 341. 1943.
Florey, H. W. War Office. A.M.D.7/90/43.
Cairns, Brigadier Hugh. *B.M.A.*, 1, 33. 1944.
Florey, M. E., and Williams, R. E. O. *Lancet*, 1, 73. 1944.
McKnight, W. B., Lowenberg, R. D., and Wright, V. L. *Journ. A.M.A.*, 124, 360. 1944.
Loewe, L., Rosenblatt, R., and Greene, N. J. *Idem.*, 124, 144. 1944.
Cutler, E. C., Colonel, U.S.A. *Proc. Roy. Soc. Med.*, 37, 107. 1944.

The Intelligent Working of the Art of Healing

An Appreciation of "An Industry of Health." By T. B. Layton.
Published by Wm. Heinemann, London. *Price* 3*s.* 6*d.*

AN excellent book and one which makes enjoyable as well as interesting reading. "Industry" means "intelligent working"; and Mr. Layton's new book is a guide to the intelligent working of matters concerning health—in somehow the same way as Plato's "Republic" was meant to guide towards the intelligent working of government.

In its twenty-one chapters it discusses work and structure of the medical profession, of the Nursing and the auxiliary Services; it is a real treasure-house, full of valuable hints and original ideas as to what health work should entail, and how it should be organised. It is surprising to what detail these ideas have been worked out, and how much good advice it contains.

As we would expect of a book by Mr. Layton, it is full of "Laytonian Dicta": those delightful, concise formations of thoughts which many of us have vaguely felt—and which he has the gift to express in his vivid style, unsurpassed amongst practising medical men. Its reading will stimulate thought in medical and laymen alike; and

I deem it a good choice to be recommended to young people, about to enter the medical or auxiliary medical professions, and who want to read "what it is all about." It reveals clearly the three great features of its author; his idealism in striving for the best which can be achieved; his enthusiasm for medical work—an enthusiasm which could hardly have been greater when the author first entered the medical school and has lost nothing in freshness during the passage of time; and that sincere and deeply humane attitude to the patient which has made his clinic a respected and beloved institution in the Borough of London.

The book is written as an "Exposition of assumption B," and takes the coming of a comprehensive medical service for granted. It welcomes such a service, without being uncritical of some of the aspects of municipal medicine; it contains severe criticism of the present position and powers of the Medical Superintendent at Council Hospitals and states that it is "this interference of the clinician by the administrator" which "has stampeded most of the profession into an opposition to any suggestion of a salaried State medical service, with the result that they have left the rules of science in which they were brought up. . . ." It is doubtful whether this is a full explanation. The reviewer is neither qualified nor entitled to pass judgment upon such matters, but, in his opinion, the "pro" and the "contra" attitude to a State Medical service is mostly a symptom of preconceived economic views or political convictions, largely independent of superintendents and the like. It also seems to him that the discussion on the acceptability of a State medical service and the large amount of attention devoted to it in the medical periodicals may give students and young doctors an exaggerated impression of the powers and influence of the profession. If one is allowed to draw conclusions from Mr. Layton's remarks about the introduction of the original Insurance System, as well as from what has happened elsewhere, one cannot but feel that the institution, or not, of such a service will depend on politicians more than on doctors, regrettable as that may be. Once definite proposals reach the legislative assembly, their acceptance or rejection will depend far more on extraneous factors, *e.g.*, the trend of political opinion in the country, the result of general elections, etc., than on the wish and the opinion of the doctors, provided the majority of the population is in favour of the arrangement.

There is, however, another side to the problem. Mr. Layton's castigation suggests that in a particular case (which the author may have had in mind) a post entailing great responsibilities was held by a man of incommensurate ability. Not all municipal superintendents, fortunately, are such misfits; and, as far as the power complex is concerned, even superintendents of voluntary institutions can, at times, be inclined to give the *fortiter in re* undue precedence over the equally desirable *suaviter in modo*. However that may be, Mr. Layton's remarks touch a point of supreme importance for all medical services: the method by which the right man can be chosen for the job. The importance of this problem of selecting the best cannot be over-emphasised, and it can indeed be said that the whole progress of medicine hinges on the ability to fill the available openings to the best advantage of scientific progress as well as of the community in general. On the good selection of junior house officers depends the patients' life and safety; mediocre appointments to the Senior Staff threaten, in time, a hospital's reputation; and the appointment to teaching hospitals of men with teaching gifts as well as the willingness to lecture is essential for the education of the student. A bad choice to a position of importance and power can lead to all the horrors Mr. Layton so vividly describes. On the other hand, only too often has failure to secure the desired and deserved appointment dragged men of great gifts into a line which—though useful still, no doubt—has nevertheless excluded them from advancing medical science as they could have done under different circumstances. This applies particularly to the surgical branches of our profession, where practically everything we can achieve depends on suitable openings and facilities for long training and ample work.

How should the appointing system for the medical profession be arranged and the necessary powers distributed? How can fair choice be ensured in spite of necessary—nay, useful competition—and unavoidable jealousy? "The care of the doctor for his patients," Mr. Layton writes, "absorbs all available emotion. There is but little left for fellow workers. . . ." This, perhaps, is a good indication of part of the difficulties confronting us. It would be interesting and helpful to hear the views of the studying and younger qualified members of the profession on the methods of selection for appointments; particularly, perhaps, after their thought has been stimulated, and their outlook on the position broadened by the perusal of Mr. Layton's book. A. B. A.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE necessity for examinations in the present traditional form is a matter which from time to time excites criticism. It is suggested that the teacher is more in a position to judge best whether the candidate has reached the required standard by observation over a period of weeks or months rather than the examiners, who must form their opinion from a brief paper and an even briefer *viva*. The *sine qua non* for such a system must be the unimpeachable honesty on the part of the teachers. Even with the present narrow scope for exploiting the human factor (for examiners are human !) minor degrees of unfairness do sometimes creep in. Such instances are uproariously amusing when from one's own hospital, but call forth righteous indignation if at another. So perhaps the alternative scheme would be impracticable even where it is desirable in theory.

Examinations are to most people the most intense type of nervous strain likely to occur before the age of twenty-five. But they form a concrete goal at which to aim and thereby provide a stimulation in all fields of the curriculum. This stimulation, assuming a well-chosen curriculum, is essential to a greater or lesser extent for everyone however intense their enthusiasm, for all find some subjects uninteresting and dull. But a sense of proportion should dominate this "exam. consciousness," so that the question in the main will not be "May this be asked in the paper ?" but "How much must I know of this to be able to treat my patients well ?"

It is a boast of the hospital that it provides a more practical training in medicine than most other teaching schools. This attention to practice has been fully justified by results yet one hears with misgivings of rounds and clinics being unattended while instead "the books" are read. The surprising thing is that all examinations at the present time are practical, too, so that when clinical material is short, as it is now, it is doubly important to avail oneself of every opportunity. It has been said that when one qualifies one starts to learn medicine. We venture to suggest that perhaps elsewhere where intensive lectures are the order of the day, repeating aloud in monotonous detail the longer text-books of medicine, this is truly said. Never let this system spring up at Guy's (we have heard many misguided requests for such a one) and Guy's will continue to supply the public with the men best able to care for them.

An unfortunate tendency, and one likely to result ultimately in the lowering of the standard of medical education at Guy's, is the countenancing of degrees other than those of the Universities by the Hospital. An unusual proportion of the more sought-after house appointments have recently been given away over the heads of M.B. students, so that, while hastily venturing to say that these instances are all fully justified, yet by continuing to show complete indifference to qualifications the selection committee would virtually segregate the School from the University to which it belongs and would create a precedent in every respect undesirable to the future of Guy's.

Finally, we would like to doff the editorial hat to all who recently, despite disturbed nights, lack of clinical teaching, the aggregation of nearly five years of wartime conditions (and several other things which for reasons beyond our ken have been censored) have "satisfied the examiners."

Obituary

AN APPRECIATION.

WILLIAM NORMAN MAY, M.D.

MEN who were at Guy's during the R. M. Wingent era will learn with deep regret of the passing of William Norman May. He died in the Royal Berkshire Hospital, where he was Senior Physician, on June 12th, following an operation. He was buried in the churchyard at Sonning in the village where he had lived and worked all his life. A large number of his friends and patients gathered in the church to mourn his passing and do honour to his memory.

May will be remembered best at Guy's as a one-time editor of *The Guyoscope*. He held the usual house appointments, being house-surgeon to Clement Lucas and John Dunn and took a tremendous interest in the social activities of his day. He watched keenly the building of the swimming-bath, at the back of the "Hotel Perry," as the Nurses' Home was called in those days and was very proud of the fact that he was the third Guy's man to enter the bath the evening before its official opening. Atkins went in first with all his clothes on, followed by Bennett who took off his coat and waistcoat; but May tarried to take off his trousers as well.

May served in the Salonica Army during the last war and was at the 28th General Hospital, subsequently being attached to the 224 M.T. Co. of the A.S.C. He made a very busy practice for himself at Sonning, but found time to take an interest in the welfare of the Berkshire Regiment, the seventh battalion of which he had met in Salonica. In his moments of relaxation he devoted himself to Natural History, having a great knowledge of the water-fowl of the Thames Valley, and had made a fine collection of their eggs.

A very likeable and attractive man, he will be greatly missed. He leaves a widow and a son and daughter, to whom many old Guy's men will wish to tender their deepest sympathy on their loss.

H. L. M.

Dysentery

By G. THURSTON, M.R.C.P., D.C.H., Lieut.-Colonel R.A.M.C.

NOWADAYS a knowledge of dysentery is important for every doctor, no matter where he is practising. This article is based on experience in India, but obviously applies wherever the disease is met. The management of the case is considered rather than the epidemiological and bacteriological aspects.

Dysentery is an infection of the bowel, chiefly the large gut, characterised by the passage of blood and mucus per rectum, more or less intimately mixed with loose stools. This is not a strictly accurate definition as dysenteric organisms are often found in the motions in the absence of blood. The two main types are bacillary and amœbic, but for purposes of management it is easier to divide into acute, subacute and chronic. In the first stage the problem is that of the infection; in subacute dysentery, of repair and secondary invasion, and in chronic dysentery of chronic infection and inanition following failure to absorb food, iron and vitamins. Arbitrarily, acute dysentery lasts for a week, the subacute stage for the second and third weeks, after which the disease may be said to have become chronic. All the way accurate diagnosis is essential to proper treatment. The mortality in adult dysentery is low in well-nourished communities, but the wastage of man-hours is enormous.

ACUTE DYSENTERY.

The problems are combating the infection and dealing with the side effects of toxæmia, if any. The clinical picture is well known and the disease may start as simply diarrhœa in which the patient notices that he is passing blood. More often he feels feverish, aches all over and has a profound disinclination for effort. This is followed by any degree of abdominal discomfort up to severe griping pain and the passage of loose stools with blood and mucus. Tenesmus is a frequent accompaniment

and indicates involvement of the rectum. The only physical signs are fever, furred tongue and tenderness in the left iliac fossa. In some cases the fever is pronounced and diarrhœa slight, so that attention is deflected from dysentery as a cause of the illness. This is specially true of the Shiga type.

It is impossible to diagnose the type of infection clinically; after considerable experience the best opinion is no more than an intelligent guess. The clinical side-room, laboratory and sigmoidoscope must be used in most cases.

Many people on coming to India have diarrhœa which they dismiss as being just "the squitters." In the past this has been dignified by the title "acclimatisation diarrhœa." Often a mild chemical enteritis, this is sometimes due to infection with the dysentery group. As a rule some immunity develops and people do not suffer further attacks, but neglect of this initial infection may leave a permanently damaged intestinal mucous membrane which readily falls a victim to later infections.

According to the nomenclature of diseases we can place our cases in five groups :—

1. Diarrhœa.
2. Dysentery clinical.
3. Dysentery bacillary exudate.
4. Dysentery bacillary Shiga, Flexner, Sonne or Schmitz.
5. Dysentery protozoal amœbic.

The stools are examined as follows :—On admission the patient is put to bed and no treatment is given until a stool has been passed. The first stool should be passed into a warm bedpan, urine being voided into a separate vessel. It should be examined —(i) naked eye ; (ii) by removing a piece of mucus with a wire loop or match, washing in warm saline and immediately transferring it to a warm microscope slide. The slide can be kept warm by placing on it a heated coin. The attention to warmth is necessary to prevent amœbæ from losing their motility. Yet it is surprising how often stools are sent by post to a laboratory with a request for examination for entamœba histolytica. It is convenient to have an annexe to the clinical side-room where the patient can defæcate, as there are comparatively few cases in which he is confined to bed. This room can also be used for sigmoidoscopy. (iii) A piece of mucus is placed in glycerine-saline and sent to the laboratory for culture. In India hospital sweepers are often adept at preparing stools for microscopic and cultural examination.

1. *Diarrhœa.*—The motions are liquid, but there is no blood to naked eye, no abnormality on microscopic examination barring the odd pus or red blood cell and culture is negative.

2. *Dysentery clinical.*—The stools contain blood and mucus, but no abnormality is found microscopically or on culture—a most unusual finding. It usually means that no stool has been saved for the medical officer's inspection. In actual practice this label is usually applied to the patients who give a history of passing blood, but in whom no abnormality is found on admission.

3. *Dysentery bacillary exudate.*—Exudate is the name given to the cells seen under the microscope. The exudate characteristic of bacillary dysentery contains red cells, pus cells and macrophages. If only one or two of these cell types is seen the exudate is called indefinite ; this is found after the first day or two in chronic cases.

4. *Dysentery bacillary Shiga,* Flexner, Sonne or Schmitz, is diagnosed on the results of culture. These are the four common types. In this connection it should be noted that a dysentery outbreak is seldom pure in type. Usually two or more different organisms are found in the various cases in a given epidemic. Staphylococci have not been found and the food poisoning group is found in definite explosive outbreaks.

5. *Dysentery protozoal amœbic.*—The protozoon is seen in material from the fresh warm stool. It is a typical amœba throwing out pseudopodia which engulf red cells. The presence of these distinguishes it from the entamœba coli and gives the amœba an appearance of a dress covered with sequins.

Naturally, many other formed bodies may be seen in the stools. All the ova of worms, flagellates and cysts may be seen and all have their special significance. A blood film must always be examined for malarial parasites, as malaria sometimes apes dysentery and treatment with quinine is needed. This is rare, but one of the recognised pitfalls.

TREATMENT OF ACUTE DYSENTERY.

Diet should be standardised and simple. Some people stress the need for a high protein diet if the stools are acid and a high carbohydrate one if they are alkaline, but this is too complicated. The diets given here have proved themselves.

No. 1.—Fluids only—weak tea, albumen water, raisin tea, barley water, rice water, clear soup, meat extracts, marmite or vegemite.

No. 2.—No. 1 plus jelly, junket, custard, toast, biscuits, mashed potatoes, eggs, citrated milk.

No. 3.—No. 2 plus orange juice, ice cream, chocolate, fish, chicken mince.

After this a standard light diet and then ordinary diet may be given.

Alcohol in any form is very bad for dysentery, but it may be necessary to give it to a chronic alcoholic. It should be remembered in connection with a patient's discharge that his normal social life may make it difficult for him to avoid alcohol. Normally, a change from Nos. 1 to 2 is made when the stools are free from blood and further advances are made according to the fæcal appearances. Increase should be rapid, for the dysenteric gets very hungry and he will not manufacture a formed stool until he has been given the raw material.

Bed is essential until the motions are pultaceous, but the patient may get up for baths and bowel actions.

Drugs depend on the case:—

1. Diarrhœa: castor-oil (1 ounce) and a day on fluids is usually enough.

2, 3 and 4. The types of dysentery may be all treated alike, if bacillary.

Sulphaguanidine is the treatment of choice. This is a sulphonamide derivative which is relatively insoluble, so that a high dosage can be given without fear of toxic effects. Twelve tablets are given at once and then six (four hourly) until the stools are normal. One tablet contains half a gramme and two to four hundred tablets are needed for the average case. In short supply the dose will have to be cut down drastically, but it has been found (Bulmer and Priest, 1942) that results are not so good.

Sulphasuxidine, or succinyl sulphathiazole, is less soluble even than sulphaguanidine and has a similar action.

Sulphapyridine is useful in the absence of the above two. It has the familiar drawbacks of nausea, depression, vomiting and risk of agranulocytosis. Nevertheless, it has a good effect in dysentery. Four tablets at once, followed by two tablets four hourly for two or three days are usually adequate.

Saline is the time-honoured treatment for dysentery. Sulphaguanidine has ousted this method. Castor-oil (1 ounce) is followed by a drachm of sodium sulphate (two hourly) for eight doses or until the stools are free from blood and green with bile. The salts are then given three times a day for one day and then stopped. Prolonged administration further irritates an already insulted bowel and is a potent cause of keeping symptoms going. This is commonly seen in patients who have tried to treat themselves.

With any of these methods the stool should begin to form about the fourth or fifth day. Sometimes a streak of bloodstained mucopus is seen on the surface of the stool. This comes from a healing ulcer and does not call for special treatment unless it persists.

Serum is chiefly effective against Shiga dysentery. If given at all, it must be given early and in large dosage, so that it has to be used before the laboratory result is made known. It is antitoxic rather than antibacterial. Serum reactions are much commoner in hot climates and the efficacy of serum is open to doubt. With the advent of the sulphonamide derivatives it will probably pass into disuse. A preliminary skin sensitivity test must be made in all cases. The indications are various according to different authorities, but, generally speaking, it is needed in the toxic case with furred tongue, fever and running pulse.

Bacteriophage has no therapeutic effect, but some patients value it. It does no harm as a placebo.

Enterovioform and *dimol* are intestinal antiseptics which enjoyed a vogue in the past, but have been ousted by the new drugs.

Kaolin is useful in solidifying the stools towards the end of the first week, but it is not much good for the acute phases.

Opium in any form must not be used in dysentery. It is tempting to give a quarter of morphia to the man who has passed a night racked with tenesmus, but only harm will accrue and persistence with the specific drugs will bring him ease.

5. Dysentery protozoal amœbic.—Two main methods of treatment, both making use of the specific drug emetine. Emetine hydrochloride is given intramuscularly in 1-grain doses for twelve doses over fifteen days, three days' interval being left in the middle of the course. Strict bed is essential and the course should not be repeated until a month has intervened since the last injection.

The combined treatment described by Manson Bahr (*British Medical Journal*, 1941) is suitable for the subacute or chronic case. The intramuscular course is reserved for the acute or extra alimentary forms. 6 p.m.—Last meal. 8 p.m.—Sodium phenobarbital (luminal, gardenal), 1½ grains. 10 p.m.—Emetine bismuth iodide, 2 grains in a capsule. In the morning the bowel is irrigated with sodium bicarbonate solution and 7 ounces of 2½ per cent. quinoxyl (yatren, chiniofon) is given as a retention enema. If the quinoxyl is not available sulphonamide suspended in gum tragacanth may be used in lieu.

Manson Bahr does not recommend the use of organic arsenicals, but most people follow both these courses with ten days of carbarsone, 0.25 grammes twice daily. Other names of similar drugs are stovarsol, amœbiarsone, leucarsone. These can be taken while walking about. It should be remembered that they contain quite a lot of arsenic, and at least a month should be left between courses. If the patient is passing amœbic cysts he should be given a course of carbarsone. Emetine is ineffective against cysts. During these courses of treatment diet may be fairly liberal. The ordinary light diet is suitable.

DYSENTERY IN CHILDHOOD.

This is a fell condition calling for energetic treatment. The sulphaguanidine will probably change the whole outlook, but there are no published data to establish this fact as yet. The type is usually bacillary, though it is a curious fact that the organism is often hard to isolate. Morgan's No. I bacillus is often found. It is toxæmia, rather than dehydration, that kills and, of course, dehydration should never occur in the treated case.

The usual story is that the child has a few loose stools with, perhaps, a streak of blood and does not appear very ill. A dose of castor-oil or magnesia is given by the mother, but no further action is taken. Next day the temperature is 100 degrees and the stools are still loose. On the third day the picture suddenly changes and the child looks ill, with dusky lids half closed over sunken eyes. At this stage the chances of recovery are slender. Often, however, the disease runs an acute course from the outset. All these children should be admitted to hospital; the parents are often unwilling, in which case the doctor should refuse to assume responsibility for consequences.

Treatment is directed—(1) to repair of dehydration; (2) to combating toxæmia.

1. Dehydration.—Most children will drink freely and the best fluid is half-strength saline with a pinch of sodium bicarbonate to the pint. Four ounces per pound body weight is the absolute minimum in twenty-four hours; more can often be given. Alternately with drinks of the half-strength saline give rice water or some other palatable fluid. Glucose aggravates diarrhœa and must be avoided. If there is any doubt about the child's condition or the least suspicion of dehydration parenteral fluid must be started. Subcutaneous saline is painful and only small amounts can be injected. Intravenous saline is sometimes difficult in a restless child and there may be technical difficulties. The intraperitoneal route is the most practical. Normal saline is injected with a serum syringe to the right of the umbilicus. A two-way tap makes the procedure easier, but the syringe can be disconnected and refilled again and again if the tap is not available. The saline is injected until the abdomen is slightly distended, and about 200 c.c. can be given to the average child of six months. This can be repeated four-hourly, fluid being pushed by the mouth at the same time. The use of buffered solutions, such as Hartmann's, is unnecessary as, given sufficient fluid, the kidneys will retain or excrete such ions as are needed for metabolism.

2. Toxæmia.—Sulphaguanidine is the drug of choice. Up to six months two tablets at first, then one four-hourly may be given; double this up to three years; and then, roughly, half the adult dose according to size and weight. In default, sulphapyridine. If there are signs of extreme toxicity serum must be used with due

precaution. Without being complacent, it should be appreciated that even with the most conscientious and unremitting treatment there will always be a few deaths, so the doctor must not let himself be unduly discouraged or influenced by recriminations which may be hurled at him by sorrowing relatives.

SUBACUTE DYSENTERY.

Here the problems are those of repair and secondary invasion. If there is no improvement by the end of a week the case may be said to have become subacute. Much harm may be done by overtreatment with salts at the end of the first week. The golden rule in the case which is hanging fire is to look for the entamœba histolytica. The stools must be repeatedly examined before amœbiasis is excluded, not forgetting the use of saline washes and sigmoidoscopic swabs. Apart from the two main pathogens, dysentery bacilli and the entamœba, which may co-exist, other invaders begin to creep in. The bowel has become damaged and is now a ready receptacle for them. They include giardia, trichomonas hominis, iodamœba butschlii, balantidium coli and various worms. Some of these are pathogenic, while the others are saprophytic. Usually, treatment directed to the main organisms will result in disappearance of the others.

Examination of the stools will show the presence of the organism concerned and determine treatment. A bacillary exudate is not usually found at this stage, but, if it is, sulphaguanidine is indicated. Indefinite exudate means healing bacillary or, possibly, active amœbic dysentery. Charcot Leyden crystals suggest tissue breakdown and chronicity. As this state of affairs is frequently associated with amœbic infection the crystals have been regarded as pathognomonic of amœbiasis, which is not strictly true.

Diet should be nourishing and not too restricted at this stage; the No. 3 diet is suitable.

Drug treatment depends on the findings and will be as described in acute dysentery.

The question of colon lavage now arises. This had some popularity in the past, but the multiplicity of solutions recommended suggests that none are of much value. It is well known that mucous colitis can be perpetuated by colonic irrigation, and there is no doubt that the introduction of chemicals can be very irritating. These remarks do not apply to retention enemata, as used in the combined treatment with emetine bismuth iodide. There are three main indications for bowel lavage:—

(i) Before sigmoidoscopy.

(ii) Before a retention enema.

(iii) A small bowel wash with normal saline will bring away mucous in which entamœba histolytica may be demonstrated in a doubtful case.

Giardia infestation is treated with mepacrine (atebrin) 0.1 gramme three times a day for five days. This course will often have to be repeated.

Trichomonas hominis does not give rise to symptoms as a rule. It can be treated with one of the organic arsenicals.

Balantidiasis has no specific remedy.

It has been observed once or twice that a patient who has flagellate infestation has cleared up after a course of gentian violet for threadworms. This is worth a further trial for resistant cases. The dose for an adult is 1 grain three times a day for five days.

(To be continued)

Guy's Letter

PRODIGY begets its own starvation, and there are no startling developments to report from Guy's since our last letter a month (June 26th) ago, except one that has been common to the whole of "Southern England" of late.

There have been no changes amongst the residents, although there has been a certain amount of rotation of duty on their part. Several of them have visited The Wildernesse recently for short periods.

An attractively constructed model of the suggested rebuilding of Guy's was on view a few weeks ago and excited much attention. At the instigation of someone unknown it was cunningly housed in the Nurse's Home, but an efficient system of highly suspicious sentries prevented any unnoticed infiltration into that area. Their presence, however, was unnecessary, most people, we believe, being sufficiently and genuinely interested in seeing for themselves the plans for the new hospital.

Some members of the community, including most definitely the writer, have developed a mole-like mentality recently and greatly dislike being forced up to ground surface and into daylight. However, the patients, the nursing staff generally, and the vast majority of other people do not share this spirit, or have sufficient resolve not to show it if they do—an attitude which is so easy to praise but very difficult to emulate, and for which they deserve all the credit in the world.

With regard to social activities we have nothing official to report. There has been an increase in illness among the housemen recently and, to remedy this, arrangements have been made for them to lunch in the College—a great boon and really appreciated.

Front surgery broke new ground a few days ago, when a wounded dog was brought in. Its radial (?) artery was tied off, but it was decided not to give it a back surgery card!

J. K. M.

Correspondence

GUY'S MEN IN FRANCE.

To the Editor of the GAZETTE.

SIR,—I thought your readers might be interested in a note from a Guy's man in France. The first Guy's man I met out here was Noel Glover, who was a very busy surgeon indeed. Kustow was the next man I met; he's running a Blood Transfusion Unit. Other Guy's men in Normandy are Counsell, whom I'm hoping to meet, Dickson, Geoff. Lloyd and Bruce Stevens. A pathological report came to me the other day signed by our old friend Major Navasquez. The Assistant Matron of our unit is a Guy's nurse, Miss Besley; and another Guy's nurse is also in the unit, Miss J. Barber. There probably are other Guy's men whom I haven't come across yet. At an F.D.S. I was very pleased to meet Tommy Renton, who had everything well organised. So Guy's is well represented on this side.

I didn't learn at Guy's how to sleep in a slit trench in pouring rain during an artillery barrage. However, I learnt that out here.

Things are much more comfortable now. At first surgery was at a premium. We all did surgery regardless of specialties. By now our special unit is functioning as it was intended to.

We're learning to speak French out here. The local people are very friendly and helpful. My French has improved so much that I can now understand what the Frenchman is saying when he tells me he can't understand my French.

It's a wonderful feeling to meet Guy's men out here. It makes you feel not so very far from home. And it was grand to receive the *Gazette* to-day.

My very best wishes to any of my Guy's friends who read this letter.

Yours, etc.,

SIDNEY BOCKNER,

Capt., R.A.M.C.

B.W.E.F.,
July 13th, 1944.

"NON-MEDICAL" EDUCATION.

To the Editor of the GAZETTE.

SIR,—"Passim" of June 10th and Mr. John's letter in a more recent issue of the *Gazette* expresses a feeling that there are few facilities in Guy's for improving the cultural background of the medical student and others within its walls. Surely this can in part be remedied now without waiting for a hostel system or the provision by the University of special courses on "non-medical" subjects?

May we therefore, through your pages, offer our services in this cause and invite suggestions as to how lectures or discussion groups or other ways of providing non-medical interests could be organised ? We suggest that if those interested would care to send us their ideas, we would undertake to arrange the material for presentation to an open meeting which could be held, say, early next term, when this matter could be discussed with, we hope, fruitful results.

We trust any presumption on our part may be overlooked and we should like to say that we sincerely hope to benefit by the hidden talent that is always present in Guy's.

Yours, *etc.*,

E. W. BAXTER,
E. O. HOHN,
B. J. RICKARD.

The Medical School,
Guy's Hospital, S.E.1.

Guy's Hospital Rugby Football Club

THE hundredth season of the club has passed. The centenary has been celebrated by a series of excellent games. The figures show that we were not as successful as we could wish, but all the matches, lose or win, were hard fought and greatly enjoyed both by players and onlookers. The spirit of the team was always high, and for this the credit goes to the leadership of Alan Lee. The club, too, was honoured by a distinguished ex-captain, Mr. W. D. Doherty, as President.

Of the matches during the season the match *v.* London Rugby Union stands out ; many distinguished figures in the Rugger world were there to see London triumph by a single try in the last minute of a hard struggle. Soon after this the XV was privileged to pay a visit to the birthplace of the game, meeting a Past and Present Rugby XV in The Close. It was unfortunate that the fixture with the United Hospitals had to be cancelled because of bad weather, but the Hospital has been invited to replay the fixture in the early half of next season. As for the other games the first half of the season was quite successful ; the second half much less so. This was due to the loss of men through injuries and through the calls of the Services. Those most missed were D. M. Strathie, now in the Navy, and R. D. Willcock and G. Hildick-Smith through injury. During the course of the season we gradually lost our South African members ; this, no doubt, played a big part in the deterioration of the results ! South Africa has played such a large part in the constitution of sides since 1919, that it is sad to think that there will be no more of them until the war is over. This season we bade farewell to T. L. T. Lewis, one of the most outstanding full-backs at the Hospital for many years. A. G. Albers and C. Ziervogel, second row forwards of consistently high merit ; and G. Hildick-Smith, who came in to fill Lewis's place at full back until seriously injured. D. C. Boyd remained until the end, but will not be with us much longer.

Of the deeds of the team as a whole suffice it to say that the forwards played consistently well and only rarely met their match. Besides losing two full-backs during the season the outsides lost D. M. Strathie, A. C. Macrae-Gibson and Willcock. This threw a lot on to the shoulders of those who remained, and of the new men—Jones, Dwyer and Day—who came into the side, one never felt, in spite of their strenuous efforts, that the line really had " punch."

A. B. Lee played for the United Hospitals, for the Civil Defence, in all three matches and, finally, for the Barbarians *v.* Thorneloe's XV at Leicester. D. M. Strathie was included in Thorneloe's XV. A. Batty-Shaw and E. W. Graham played for London against a Dominions XV.

In the Seven-a-sides we were beaten once again by the Middlesex Hospital in the Inter-Hospitals Seven and by R.A.F. (Jurby), the eventual finalists, in the Middlesex Hospital Sevens.

The Club ran two other teams from London during the season and a couple down in Tunbridge Wells. Co-ordination has never been satisfactory between the different teams. But now that the medical school has returned to Guy's the opportunities for this will be greatly improved. The rules of the Club were tightened up at a general meeting, and there is every sign of a successful start to the second hundred years. R. G. L. Brittain has been elected captain and A. Batty-Shaw re-elected secretary.

Sport

Cricket

GUY'S *v.* WOOLWICH GARRISON

(Played at Woolwich on June 25th.)

Result: Guy's lost by 80 runs. Score Woolwich, 196; Guy's, 116.

Guy's lost the toss and took the field only ten minutes after the appointed twelve o'clock, with Carberry and Crowder opening the Garrison innings and setting a brisk pace by taking nine runs in the first over.

At ten minutes to lunch-time four wickets were down for 61, and at five minutes to the interval the ball was in mid-air waiting to be caught and so put the Hospital well on top. This, however, did not occur, and Dawes, a punishing bat, who played the stroke at 5 went on to make 38.

After lunch Dawes was soon joined by Lindsey, who gave the best batting performance of the day, cutting and driving good and bad alike before he was stumped by Brittain for 67 in attempting a single at the end of an over. Saunders returned the best bowling figures with four for 32.

Guy's were left two and three-quarter hours to make 196, but somehow, although many of our batsmen shaped well, none got very far. Thompson, at 26, was the highest scorer and was, perhaps, unlucky to be taken brilliantly by Gouff in the gully. Sheerboom, with four fours in his 22, was out to the wildest of strokes, and Saunders, at 17, was caught at the wicket. The innings ended with but 116 runs on the board.

Team.—E. G. Murphy, L. D. Carton-Kelly, D. R. S. Saunders, G. Thompson, R. G. L. Brittain, D. J. Sheerboom, A. E. Trist, E. W. Graham, K. G. B. Pritchard, I. L. Burbridge, J. D. Williams.

GUYS *v.* MALDEN WANDERERS.

(Played at Malden on Saturday, July 1st)

Result: Guy's lost by 44 runs. Score: 155 for nine; Guy's, 111.

With rain expected and on a sodden wicket the Malden Wanderers decided to bat. Trist soon had the earlier batsmen in trouble and three wickets were down for 26, when Van der Berg joined Buchanan and the score advanced at an alarming pace. At 108 Buchanan left with 69 to his credit, as also did Van der Berg with 24; and, later, Malden declared at 155 for nine.

With two hours to go Guy's opened their innings and, apart from Thompson's swift 22, gave an admirable exhibition of how to attempt the drawn game. At 70 Carton-Kelly arrived to demonstrate the quality of the long handle and collected 31 runs in three overs, including two 6's and three 4's. On his departure the remainder could only muster a further five runs and Guy's were all out for 111.

Team.—L. D. Carton-Kelly, G. Thompson, I. A. H. Munro, A. E. Trist, I. L. Busbridge, F. R. Lambert, J. D. Williams, W. A. Evans, P. C. Matthews, M. J. L. Sykes. (Only ten Guy's men played.)

Hospital Information, etc.

Notices

NUFFIELD HOUSE.

Applications are invited from Qualified Medical Practitioners unfit for service for the post of Resident Medical Officer to Nuffield House (Pay Bed Block of 34 Beds), Guy's Hospital. This post is graded B 2, and carries a salary at the rate of £250 per annum with full residential emoluments. The appointment will be for a period of six months in the first instance, but this will be extended for a suitable applicant.

Applications should be sent to the Secretary of Nuffield House, Counting House, Guy's Hospital, not later than August 21st, 1944.

Guy's Hospital

SCHOLARSHIPS IN ARTS AND SCIENCE.

The following awards have been made for 1944:—

Medical School.

Entrance Scholarships in Science, each of the value of £100, to David George May (Surbiton County School) and Anthony James Salmon (Bradfield College).

Entrance Scholarship in Arts.—No award.

Dental School.

Entrance Scholarship in Science, of the value of £40 per annum for four years, to John Hugh Keeling (Guy's Hospital Dental School); and an additional Scholarship of £40 per annum for four years divided between Samuel Stanley Epstein (Willesden County School) and Alan Arthur Robinson (Tiffin Boys' School, Kingston).

Entrance Scholarship in Arts.—No award.

Pass List

CONJOINT BOARD.

FIRST EXAMINATION.

June, 1944.

Anatomy.

G. L. Blewett — E. M. Sycamore
R. French — P. J. F. Walsh
A. J. I. Kelynack

Physiology.

G. L. Blewett — A. J. I. Kelynack
M. P. Cardew — J. B. Morrison
L. J. Evered — P. Read
R. French — J. Southgate
A. L. Jeanes — R. L. Timms
S. P. Johns — P. J. F. Walsh

Pharmacology.

D. F. V. Brunsdon — B. D. Grant
D. W. J. Cullingford — F. F. Jerichower
D. J. Dennison — C. M. Ruben
R. V. H. Goulder

PRE-MEDICAL EXAMINATION.

Chemistry.

L. Becker — C. R. Wilkinson
M. B. Lacey

Physics.

A. A. Bailey — J. W. McLean
D. G. Bunker — D. K. Minton
H. E. Dyer — G. G. Phillips
A. V. Gledhill — K. S. Sunaway
A. A. Krantz

Elementary Biology.

H. E. Dyer — K. S. Sunaway
A. V. Gledhill — R. E. S. Turner
G. G. Phillips — G. P. Williams
B. S. Saunders

ROYAL COLLEGE OF SURGEONS OF ENGLAND
AND
ROYAL COLLEGE OF PHYSICIANS OF LONDON.

Diploma in Anæsthetics.

H. A. Buck — F. J. R. Stoneham
J. T. Linklater

ROYAL COLLEGE OF SURGEONS.

L.D.S.

FIRST AND SECOND PROFESSIONAL EXAMINATION.

Dental Metallurgy.

H. E. Braun — M. P. O'Reilly
R. E. Feaver — F. E. N. Preston
M. W. Harber — A. P. Rowland
J. K. Keen — D. F. Waller
J. G. L. Knowles — K. D. Watts
D. W. Leatherbarrow — S. F. A. Westgate
H. Lewy

Dental Mechanics.

I. N. Busbridge — G. J. Marks
L. D. Carton-Kelly — G. R. M. Mote
R. K. Foster — R. A. J. Shaw
P. C. Hadley — P. B. Smith
D. G. D. Harris — J. R. Waller
P. S. Holmes — R. S. Wilson
E. T. Hunt — E. J. Williams
R. G. Iliffe

Anatomy and Physiology.

P. S. Holmes — C. W. H. Williams
E. T. Hunt — R. S. Wilson
M. J. L. Sykes

Special Anatomy and Physiology.

J. E. E. Attale — R. T. Lowein
C. C. Bull — G. J. Marks
L. D. Carton-Kelly — P. Maxwell-Stephens
G. T. Crook — K. G. B. Pritchard
J. F. H. Flanders — J. D. Rumble
H. C. Goudge — A. J. Swann
W. D. Hannaford — G. Thompson
E. K. Harris — I. D. L. Thomson
C. M. M. Jenkins — B. Wotton
W. O. King

L.D.S.

FINAL EXAMINATION.

PART I.—Surgery.

J. B. Andrew — N. S. McKie
D. J. Gray — N. T. McNeil
J. D. Green — A. G. Starte
E. K. Harris — E. H. Sudell
A. C. Keith-Fraser — H. Wertheim

PART II.—Dental Surgery,

J. B. Andrew — A. C. Keith-Fraser
D. C. Boyd — N. T. McNeil
H. S. M. Crabb — D. S. Nelson
L. J. Crane — S. C. J. Pink
D. C. Dawson — J. G. Richards
D. R. Edwards — M. G. Trott
J. A. Ireland — H. Wertheim

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

June, 1944.

Surgery.—A. G. I. Stockley.

Medicine.—M. J. Blunt, *K. R. J. Coates, E. A. Humphrey, R. A. Leeming.

Midwifery.—A. G. I. Stockley.

* Has completed the examination.

Papers by Guy's Men

Witts, L. J. Some problems of Infective Hepatitis. *Brit. Med. J.*, 1944, i, 739.

Croft, A. W. J. Prostheses for Children. *Lancet*, 1944, i, 639.

Ryle, John A. Rectal Pain. *Clin. J.*, 1944, 73, 85.

——— Education for Health. *Lancet*, 1944, i, 713.

Exner, G. G. Treatment of the Third Molar Tooth. *Medical Press*, 1944, **211**, 216.

——— Some aspects of the Impacted Third Molar. *Med. Pr.*, 1944, **211**, 234.

MacManus, Desmond. The Home Guard Medical Service. *Med. Pr.*, 1944, **211**, 329.

Change of Address

E. W. Baxter, B.Sc., F.Z.S., 32, Court Drive, Croydon, Surrey.

c/o D.D.M.S. Headquarters, A.A.F., C.M.F.

P. L. Blaxter, Lieut., R.A.M.C., 306039 R.C. 266, A.P.O. 7450.

J. Cranfield, Captain, A.D. Corps, 27 Field Dressing Station, B.W.E.F.

C. S. Darke, Major, R.A.M.C., No. 3 (E.A.), General Hospital, East Africa.

R. T. Hinde, Surg.-Lieut., R.I.N.V.R., c/o Grindlay & Co., Parliament Street, S.W.1.

D. Hand-Bowman, Captain, A.D. Corps, 33 Field Dressing Station, B.W.E.F.

T. L. T. Lewis, Lieut., S.A.M.C. (544889),

Awards

Birthday Honours

O.B.E. (Military Division).

Wing-Cmdr. C. A. Rumball, R.A.F.

R.N.V.R. Officers' Decoration.

Surg.-Lieut. Cmdr. H. E. Holling, R.N.V.R.

D.S.O.

Capt. (Temp. Major) B. G. A. Lilwall, R.A.M.C.

R.R.C. Awards

Miss Nancy P. de B. Bampton, Q.A.I.M.N.S. (Guy's 1922–26), Principal, 73rd General Hospital.

Mentioned in Dispatches

Wing-Cmdr. R. W. B. Ellis, R.A.F.V.R.
Wing-Cmdr. C. R. E. Freezer, R.A.F.V.R.
Sqdr.-Ldr. J. McA. MacArthur, R.A.F.V.R.

Deaths

BRABIN-SMITH.—On June 13th, 1944, at Bedford, Lettice Brabin-Smith (Guy's, 1933–39).

BRABNER.—In June, 1944, by enemy action while on hospital duty, Dr. Jean Gwenneth Brabner-Smith, elder daughter of Mr. and Mrs. W. W. Brabner-Smith, of Loughton, Essex (Guy's Massage, 1932–35).

BUCKERIDGE.—On July 14th, 1944, suddenly, in London, Surg. Rear-Admiral Guy Leslie Buckeridge, C.B., O.B.E., the beloved husband of Nellie Buckeridge, son of the late Walter Buckeridge, of Norfolk House, Angmering, Sussex.

DAW.—On June 19th, 1944, at Polegate, Sussex, Samuel Wilfrid Daw, F.R.C.S.

FAGGE.—On July 12th, 1944, at Lacey Green, Buckinghamshire, Beatrice Dora Fagge (Guy's, 1893–94), aged seventy-nine, widow of C. H. Fagge, M.S.

NAWN.—On July 9th, 1944, in Bright Ward Nurses' League Bed, Josephine Nawn, A.R.R.C. (Guy's 1900–1905).

WHITE.—On June 28th, 1944, Eustace White, L.D.S., R.C.S., of 61, York Road, Cheam.

WHITE.—On June 24th, 1944, at Tracy Nursing Home, Banbury, Richard Watts White, M.R.C.S., L.R.C.P., of Barons Court, Rustington, Sussex, aged eighty-nine.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LVIII. No. 1462 *5th August, 1944* *Ninepence*

PASSIM

AT a recent meeting of the King Edward's Hospital Fund for London, the Duke of Gloucester, who presided, announced that the sum of £300,000 was to be made over to the King's Fund from the Nuffield Trust for the Special Areas. Lord Nuffield has asked that out of this total the sum of £250,000 be granted to Guy's Hospital to help towards the reconstruction of the Surgical Block.

We at Guy's know Lord Nuffield's generosity of old; how his interest in the Hospital and the welfare of its patients has never wearied, and it is further gratifying to know that he is so eager to see the Hospital struggle to its feet once again from the dust and rubble. Not only to rise again, but to grow so that it may now become a thousand-bedded hospital, not only ready to serve again in the old tradition, but to serve with much finer facilities both for patients and staff.

We feel sure that old Thomas Guy would be smiling to himself were he to know that someone had not forgotten the scale of his munificences !

WE hate bringing up this perennial subject of ward rounds, but the situation—at least as far as medical rounds are concerned—is becoming ridiculous. One of your Editors, foregoing his usual afternoon nap, went on one of Dr. Douthwaite's rounds. It says much for Dr. Douthwaite's popularity, but the patient was invisible most of the time since there were at least fifty students by the bedside. Fortunately, Dr. Douthwaite is taller than the average and one could lip-read.

But seriously, we feel that some definite action should be taken, for at the moment these rounds are quite valueless, at any rate, to the senior student, who does not have the added advantage of a Registrar teaching on the same cases to a smaller audience. It is also the senior men who have not had the benefit of the teaching of the honorary staff in their ward-clerk days, which were chiefly spent in one of the Sector hospitals.

What is the remedy ? It seems unfair to exclude people preferentially from these rounds, so we suggest that it might be a better plan for arrangements to be made to use the clinical material at other local hospitals and, lest too great a strain be thrown on our already overworked registrar, invitations might be extended to doctors outside the Hospital to help with these teaching rounds provided that they have the time and are willing and suitable for the job.

If these arrangements could be adopted, as they have before, we feel sure that the congestion on rounds would be considerably reduced to everybody's benefit.

THE Goodenough Committee's Report (H.M.S.O., 4*s*. 6*d*.) has recently been published. Its 312 pages have eluded us up till now, but when we have the time (and 4*s*. 6*d*.) we hope to be able to write a few notes on it. It would appear to hold out some very far-reaching proposals and should be well worth reading.

THE following is an extract from the *Journal of the Indiana State Medical Association* (June, 1944) :—

> "The members of the Indiana Association of the History of Medicine were entertained at the home of Dr. and Mrs. Edgar F. Kiser, of Indianapolis, on May tenth. Doctor Kiser, in his inimitable manner, gave a graphic description of the history of the famous Guy Hospital in London, founded by Sir Thomas Guy in 1724, and described the almost continuous two-year German bombardment in 1940 and 1941 (which, however, failed to destroy the hospital) and the work involved in maintaining the hospital services.

"The information concerning the Guy Hospital had been supplied by Captain B. D. Rosenak, of Indianapolis, who is with the Medical Corps in England."

We feel that we ought to correct Dr. Kiser on two small points. The Hospital is usually known as Guy's Hospital and, as far as we know, Thomas Guy never received the title of knighthood.

Our cartoon may need a word of explanation. Sister Florence Taylor reports that on one of her trips in Southern England a "doodle-bug" narrowly missed her car. Our nurse cartoonist was inspired to record this wonderful piece of evasive action by Sister Flo.

Obituary

RICHMOND EDWARDS.

In an institution like Guy's no one can be indispensable although some are outstandingly brilliant in the service of the hospital and of medicine. Their achievements are known throughout the land and their records are written for all time in the annals of fame. There are few, indeed, of these men who have not given credit for their ability to the Hospital in which they were taught and in which they work. Their success and their vitality are derived not only from their own initiative, but also from the stimulus they receive from the vigorous traditions which their hospital possesses and the permeation of their lives with its spirit. Guy's has been rich in such men and such an atmosphere.

This atmosphere cannot really be described. It is compounded basically of freedom, responsibility and service. Before the war Guy's in its fullness of life flourished on it. It is one of its most precious possessions.

This article is written in appreciation of Richmond Edwards, whose name has not yet been mentioned. That is as he would have it. He was not one of the famous; he was not on the staff; and he won no prizes. His most eminent distinction would be noted in the official records as having been President of the Residents. In reality his most eminent distinction was his independence of mind, his ready and generous acceptance of responsibility and his love of service. Words are clumsy instruments to use to describe a character blended of industry, modesty, a respect for learning, humour, of friendly acts and quips, and of contempt for affectation and for the philosophy of "getting something for nothing." So clumsy, indeed, that it is impossible to go further than this light etching of the main facets of his nature which gave delight to his friends and comfort to his patients.

He would be the last to admit that any of these remarks applied to him. Yet it is of such qualities as his that the essence of Guy's tradition is made. Without them Guy's would indeed be cold and sterile. All who knew him will mourn that he should be "missing at sea." All who knew Guy's in his day know that as long as the Hospital maintains its personality he will live on. P.A.G.

Dysentery

By G. THURSTON, M.R.C.P., D.C.H., Lieut.-Colonel R.A.M.C.

(Concluded)

CHRONIC DYSENTERY.

The problems here are those of repair, secondary infection, inanition and mental depression.

The ordinary satisfactory case of dysentery has now become convalescent. It is important to keep the case of amœbic dysentery under observation for a month before allowing him to go back to duty. He should be allowed gradually to resume his normal diet and habits during a test period. It was formerly the custom to insist on three negative stools before a case of bacillary dysentery was pronounced cured. With a large number of cases to deal with the laboratory is likely to be swamped with work and much valuable culture media will be wasted to no purpose. In practice it is hard to get a positive culture after the second or third day and, if the stools are normal and the patient is symptom-free, he may be regarded as cured. Similarly with amœbic

dysentery, though here it is essential to have the stools examined for cysts. He should also come back once a week for stool examination for as long as is practicable. No case of dysentery which has not pursued a perfectly normal and straightforward course should be discharged without a sigmoidoscopy; after all, one does not treat tonsillitis without looking at the throat. In rush periods, when the sigmoidoscope has gone wrong or in primitive circumstances it may be impossible to fulfil these standards, but they are given as an ideal of treatment.

Sigmoidoscopy.—This should not be performed in the acute stages, but the beginner will do well to examine one or two acute cases to get a picture of the appearances. Illustrations given in text-books are misleading, and the only way is to gain practical experience.

During the subacute stage healing processes may be observed. In some patients who persistently pass blood the source may be seen to be a single ulcer. This should be touched by a piece of wool dipped in 50 per cent. silver nitrate on the probe. Such applications should only be made to the solitary kind of ulcer. In the chronic cases the exact extent of the mucosal damage can be studied.

Technique is simple. Some people pass the instrument without preparation, but preliminary irrigation makes it easier. The patient has a bowel wash-out the night before and immediately before the sigmoidoscopy. No anæsthetic is needed, but morphia ¼ grain may be given to an apprehensive patient (very unusual). The examination is best done in the knee-elbow position, with the anus on the level of the observer's chest. A petri dish of warm saline, glycerine saline for culture of swabs, and a spirit-lamp should be at hand. The warm saline is used in looking for amœbæ in swabs. The sigmoidoscope is warmed up in the spirit-lamp or hot water and greased up to the 10-inch mark. The light and bayonet joint for the obturator are tested. The gloved forefinger is passed through the anus in case there is a fissure or other abnormality which may prove painful. Many people have piles as a result of purging in dysentery. The instrument is then gently introduced, aiming in the direction of the patient's umbilicus. As it goes through the anal canal the handle descends towards the patient's heels. The obturator is removed and further passage done under direct vision. It is seldom necessary to use the bellows which cause a lot of pain. Secondary infection is much the same as in subacute dysentery and needs the same treatment. A common mistake is to get a man who has had chronic dysentery for, perhaps, six months, and then suddenly to find a Sonne or other bacillus. This does not mean that it has been missed; further examination may reveal amœbæ as well. It is necessary to realise all the time that the mixed infection is the rule rather than the exception. In the chronic stage, however, drugs play a minor part.

The malnutrition needs careful treatment. Diet should be as full as is compatible with the avoidance of relapse. The attention of a sister skilled in diet is invaluable here, as she will give the patient the maximum compatible with his bowel condition. The No. 3 diet, again, is important and care must be taken to see that the calorific value is sufficient. At least 3,000 calories a day is needed by the average European. Patients in this stage are frequently emaciated in the extreme. It is difficult to diet Indian patients, as they are loath to eat food to which they are unaccustomed. However, modifications have to be made to suit the individual.

Anæmia is always present in the chronic dysenteric. Where the red count is less than 2.5 million a blood transfusion is indicated. This must be given very slowly indeed, as reactions are common and the heart muscle may have undergone degeneration from the disease. Fresh is better than stored blood. This can be repeated until the blood picture is normal, if hæmatinic drugs do not have effect. The anæmia is usually of the mixed type, and both iron and liver should be given. There need be no hesitation in giving iron to the dysenteric. Liver extracts are best given intramuscularly.

There is a great vogue for synthetic vitamins, but if the patient is having a proper mixed diet he is undoubtedly getting a good supply of natural vitamins. Vitamin extracts may be valuable, but they are regarded by many people as a substitute for food. It is best to prescribe them for definite indications. Vitamin B for neuritis, ascorbic acid for bleeding or spongy gums, nicotinic acid for sore tongue, and riboflavin for angular cheilitis. Anæmia, at least, can always be repaired.

After a patient has been in hospital a month or two he is naturally getting depressed mentally. He is mistrustful of treatment and non-co-operative. He has often been over-treated and under-fed. If he has been on a low diet the first thing is to give him some food. It is as well to lay all the cards on the table and explain that treatment is to be a lengthy business—rather like the sanatorium treatment of tuberculosis.

Very often, with a full diet and the omission of medicine, his condition improves rapidly. The connection between the psyche and the colon has long been well recognised and a bad mental outlook will perpetuate symptoms, especially the copious secretion of mucus. Conversely, some do badly from the start; they are usually the introspective and conscientious. The aggressive, happy-go-lucky type recovers quickly from his diarrhœa. Sometimes it may be desirable to send the patient out of hospital for a spell even though he still has symptoms; it may harm the intestine, but may also avert a mental breakdown, which is harder still to treat.

The Indian sepoy presents a different problem. Being a simple-minded person he is liable to sink into an apathy in which he literally lies down and dies. Much depends on the attitude of sisters and ward servants. Comparatively few patients fail to respond to the above measures, and the extended use of sulphaguanidine promises better results still.

In the face of persistence of the chronic dysentery other diagnoses must be considered, and these should be in mind right through the course of the disease.

1. *Sprue*, in its partially developed form, is quite common and may start acutely. This condition is the subject of much debate and exact knowledge of its ætiology is still wanting. It may supervene on dysentery or arise *de novo*. It may be defined as a condition in which the passage of pale bulky frothy stools is accompanied by rapid loss of weight, abdominal distension, sore tongue and, later, anæmia. Pathologically there is atrophy of the intestinal mucous membrane. There is no doubt that a lot of the characteristics of sprue are the result of failure to absorb the extrinsic factor and vitamins. It is important to recognise that in sprue there is a tendency to spontaneous improvement and relapse. While the sprue sufferer is especially liable to infection with protozoa and dysentery bacilli the essential feature is that the syndrome exists in the absence of fæcal pathogens. Estimation of the fæcal fat content is important and the necessity for this is indicated by the clinical condition of the patient and the presence of an excess of fat globules in the microscopic examination of the stools.

2. *Mesenteric tuberculosis* may be activated by dysentery and the picture is one of diarrhœa and emaciation. Sigmoidoscopically the bowel is normal and the stools are loose, but contain no abnormal cells. There is little point in examining the stools for tubercle bacilli, as the procedure is complicated and chancy. Ascites does not usually occur and masses are not always felt in the abdomen. As emaciation is extreme in chronic dysentery the tuberculous process is often only discovered at autopsy.

3. *Muco-membranous colic* is a visceral neurosis in which masses of mucus, sometimes taking the shape of a cast of the bowel are shed with a feeling of weakness. The patient may describe this as "frog spawn." It is familiar in better-class European practice, but in India it often follows dysentery, especially in the neurotic person. The patient inspects his own stools and decides that he still has dysentery, as in the beginning. He treats himself with frequent doses of salts which irritate the colon with further production of mucus. In this way a vicious circle is started. The mental attitude is usually anxious and minute descriptions of the motions are given. As often as not the patients will bring a specimen in a cigarette tin and thrust it suddenly under the unsuspecting doctor's nose. Microscopic examination of the stools shows the absence of cells and culture is negative. The treatment is discouragement of stool-watching and self-dosing and fostering of interests outside the patient's ego.

4. *Lienteric diarrhœa*, in which the bowels are urgently opened after each meal is a common legacy of dysentery. So long as the patient feels well, maintains his weight and energy and has no pathological constituents of his stool it is best untreated. This is probably the only condition in which opium may do good and 5 minims of the tincture may be taken before each meal for ten days.

5. *Carcinoma of the colon* is commoner in people over forty, but every now and then a young adult has this condition. Attention to the symptoms, sigmoidoscopic appearances and the absence of the dysentery bacilli should suggest the true diagnosis, which will be confirmed with a barium enema.

6. *Ulcerative colitis* has usually a long history of remission and relapse. There is a large amount of blood passed and a general consideration of the case will point to the diagnosis. Incidentally no one with this, or any other bowel complaint, should be allowed to proceed to the tropics.

7. *Hyperthyroidism* is sometimes mentioned as a cause of unexplained diarrhœa, but there are usually other features of the disease which are more striking.

8. *Bilharziasis* will be suggested by a history of residence in an endemic area and by microscopic and sigmoidoscopic appearances.

It can be seen that the treatment of dysentery is a systematic business. The acute

case usually clears up quite well, but in the chronic phases much patience is needed and the *régime* is similar to that used in the sanatorium treatment of tuberculosis. Drugs, though to a certain extent specific, will never replace good dieting and attention to the mental aspects of this depressing disease. When confronted with a ward full of men who have been hospitalised for a year or more it is hard to be optimistic, but the mortality is surprisingly low, and it is well to remember that the vast majority eventually recover without ill-effects.

REFERENCES.

Bulmer, E., and Priest, W. M.. (1942.) *Journ. R.A.M.C.*, 79, 277.
Manson Bahr, P. (1941.) *Brit. Med. Journ.*, 2, 255.

Another Letter from "Sinbad"

Dockyard,
c/o G.P.O., London,
May, 1944.

MY DEAR BILL,—When I thought of writing this I was ashore, but now I have another ship, so that in the last six weeks I have discovered some of the problems of going ashore and am sampling the difficulties of a new ship once more.

You are unlikely to be left more than fifteen to eighteen months in a destroyer on a home station; at the end of about nine months you should go up to the Medical Department. A satisfactory feature of the Navy is that you can always go up to the Medical Department to suggest what you would like to do in your next job, although this suggestion may not be implemented. You should be clear in your own mind what you want to do and give alternatives, and let the appointments branch know well in advance. Be brief and, finally, do not make a fuss about the hardships of sea life; incredibly, some people do. The answer is clear: "Why did you join the Navy?"

Shore work must be looked upon as a privilege which may come to an end suddenly; it makes life less disturbing not to bank heavily on anything.

After your visit to the Admiralty you should start making preparations for leaving the ship. You don't pack up; but get hold of a wooden box for your books. I have a folding bookcase which is convenient. Get your S.B.A. to prepare a duplicate list of all drugs, instruments, dressings, etc., carried to take ashore with you. If you should go to a new ship this will save much thought and trouble; I failed to make this provision and regret it now. Check over your bags and trunks; if they are insufficient, you can usually persuade someone to make you a large, strong canvas kit-bag to hold all linen and shoes. One day you will get in from a trip, a signal will come through and someone will say: "Why, Doc, your relief has been appointed"; and you will feel sick and guilty, almost as if you were deserting them. Don't be surprised if he doesn't turn up for some days or even weeks, as happened in my case. The time before his appearance should be spent on checking over stores, getting your books in order and, when his arrival seems imminent, packing your own gear. Packing is always unpleasant, but I have seldom found it more distasteful than in my last days in the *Verucca*; in the words of Katherine Pinkerton, "If one must leave a ship, a home or a woman leave should be taken while one is still in love."

For handing over you should have a couple of days. I was lucky enough to have twenty-four hours at sea with my successor, and, in this time, there were many points which we discussed. In theory you hold an accounting down to each pill; such a practice is clearly impossible, but it is desirable to check the sick mess account and the dangerous drugs carefully.

While you are handing over it is wise to signal to the Medical Department that your captain intends to send you on leave from sea, and it is customary to write to your new commanding officer acknowledging your appointment and informing him of the leave which you have been granted and when you intend joining. There is a proper way of doing this. The letter begins: "Sir,—I have the honour to acknowledge my appointment to —— under your command" and ends: "I have the honour to be, Sir, your obedient servant." I have always regretted that the Nelsonian habit of referring to fellow-officers in official correspondence as "dear and esteemed brother" seems to be in abeyance. It is useful to know that an officer usually "proposes" to his juniors, states his "intentions" to his equals, and "requests" his seniors. You would not, for instance, propose to the Medical Director.

Immediately you get on leave sort your gear into three categories: that which is essential to have with you; that to be kept ready to send to you immediately you are

appointed to another ship; and, finally, the miscellaneous junk. Surgical instruments and special equipment should be carried with you. An addition which is reassuring to carry is a couple of 6-inch needles for splanchnic block by Dr. Norman R. James, method; he very kindly got Messrs. John Bell, of Croydon, to send them to me. His little book is probably the answer to anæsthesia for emergency abdominal operations done single-handed.

A problem which faces all doctors in war-time is that of offenders; it is useful to have a policy towards them since executive officers are becoming increasingly keen on getting a medical opinion upon odd and queer fellows who get into trouble, and this compliment saddles us with considerable responsibility. You can make three recommendations:—First, there are no medical reasons against punishment; second, that there are extenuating circumstances, but that the man, understanding the nature and quality of his offence, is fit for some form of punishment; third (we are considering mental illness only) that he is too ill to be punished. If he is unfit for punishment, he should be put sick and preferably sent off the ship; his fellows must never get the impression that he "has got away with it by seeing the quack," since this would be an incentive to malingering. In the second group punishment and treatment are combined with emphasis upon whichever of the two is appropriate. I have been told that in barracks about 90 per cent. of the cases seen are those who do not require medical assistance and are purely disciplinary problems.

A small but important class of men are those who become unduly sensitive to alcohol after head injury, and this may bring them to you as offenders. This is sometimes associated with dementia. The subject is discussed in Curran and Guttman's short book on psychiatry, priced 10*s.* 6*d.*, very useful both for its general information and special reference to the Navy.

When you see offenders, officers and men must understand your position. You are not a Gestapo agent giving refined third degree; the accused must be assured that nothing that he tells you will increase his punishment, and that, if he tells you the truth, it may be possible to help him. In this way the thin ice of professional secrecy remains uncracked.

Morale is not a medical problem, but you can assist by observing its state and health The first lieutenant, upon whom the responsibility for its maintenance falls most heavily, will, if he has confidence in your judgment, occasionally ask you "if anyone is nattering about anything," and you should then make your suggestions, but, unless invited to do so, it is better not to poach upon his preserves; the justifiable ill-feeling this will cause far outweighs any good you might possibly achieve.

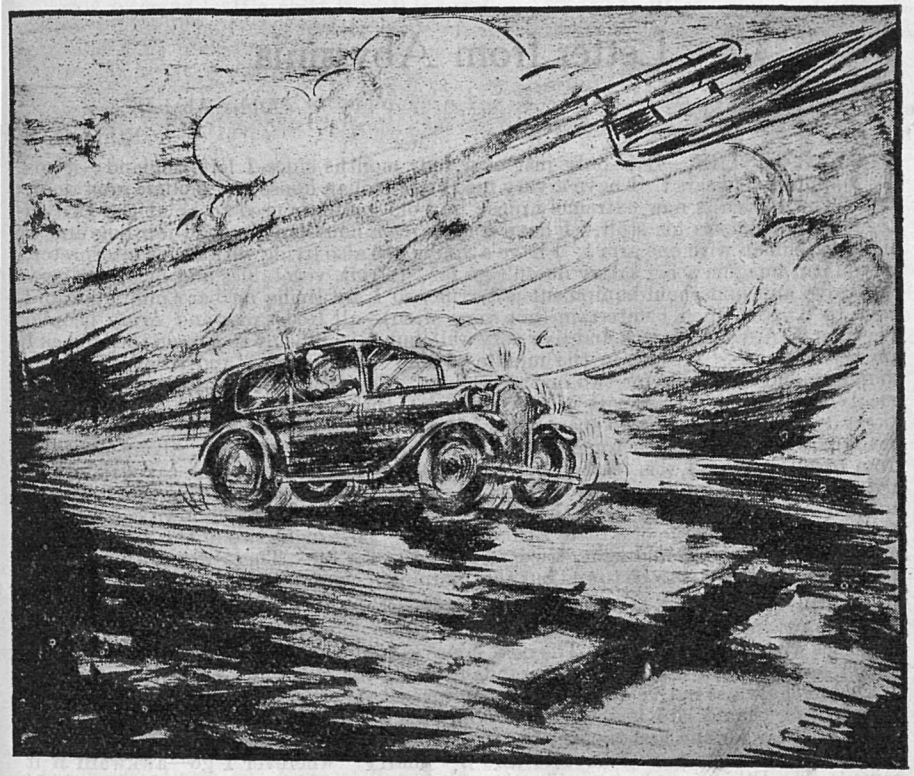
Early on get to know the coxswain, chief boatswain's mate, gunner's mate, leading hands of messes, and one or two of the old three-badge A.Bs. (badges are the red chevrons worn on the arm indicating years of blameless service or, some say, undiscovered crime; three mean thirteen years); they will often be able to tell you more than young leading hands. From these sources you can soon get to know how things are going on the mess decks and how new entries, especially youngsters, are settling down. In this manner and by interviewing every man when he is drafted to the ship, you can prevent some unhappiness and, when it occurs, treat illness early. Sailors do not resent an interest in their welfare, and in the dog watches you can learn, if you care to, strange things about the sea in general and your ship in particular.

Some people enter the Service as martyrs renouncing medicine; this defeatism causes opportunities for the exact observation and careful record of the health, living conditions and habits of sailors to be lost. Information is needed upon the diet, cooking, time and duration of meals, use of stomach powders and other factors associated with dyspepsias in sea-going ships. One of the writers of the "Naval Medical History of the War" tells me that this detailed and accurate accounts of messing are very hard to get.

Sea-sickness remains enigmatic. Lately an account in *The Lancet* showed that hyoscine is useful for short trips, but, in my experience, it is not much help on longer voyages. Extensive reading has convinced me that we are still very ignorant about this widespread affliction. I found in my small series of cases that some of the persistently seasick (more than five days' vomiting) will recover if given narcosis with nembutal for twenty-four to thirty-six hours combined with suggestion. One case of persistent seasickness was undoubtedly associated with psychological trauma in youth, which came out well under narco-hypnosis, but relief was only temporary. On this and other subjects we have plenty to learn. A number of doctors co-operating in a group of escort vessels or a destroyer flotilla could plan their work to cover some subject thoroughly and from the greater number of cases observed gain more significant results.

Au revoir

"SINBAD."



Correspondence

DENTAL CLINICAL PERIOD.

To the Editor of the GAZETTE.

SIR,—The Dental Council of this Hospital has recently extended the clinical period of study of dental students from twenty-four months to twenty-eight months.

This decision is over and above any regulations proposed by the Examining Board in England. In the midst of war this seems a curious decision and even, more remarkable when one considers that our clinical appointments are held for periods of three months. The B.D.S. student is, or has been, allowed to enter for L.D.S. finals after only eighteen months of clinical dentistry—an enviable position, if slightly incredible. We—the humble L.D.S.—presumably can wash out any slight suspicion of a taste in the inevitable 2 per cent. carbolic.

Yours, etc.,

Guy's Hospital, London, S.E.1. B. S. J. SWANN.

DEARTH OF SOCIAL ACTIVITY.

To the Editor of the GAZETTE.

SIR,—It is noticeable that Guy's is the only major hospital which has no form of social activity at the present time. This state of affairs has existed for no accountable reason since the New Year. It has been said that air-raids constitute an argument against social activities, but, nevertheless, many of the large London hospitals manage to hold a dance fortnightly, or even weekly.

Surely, in these days of stress, a little relaxation would be of great benefit to those residing in the Hospital ?

Yours, etc.,

"VOX POPULI."

Letter from Abyssinia

Addis Ababa,

Ethiopia.

DEAR SISTER,—It is only just over four months since I left England—seems quite four years ! I have a very nice little Italian house and a clinic next door. The garden is now extremely nice ; my old gardener used to be at the British Legation and knows his stuff. I have a cook *-cum-*houseboy, an odd-job boy and a night watchman with one arm ! I have a young girl also living with me as interpreter, so you can imagine a big salary doesn't go far ! Fruit, vegetables and meat are very expensive and household equipment is terrific, so I am living on bare minimum and have to borrow when I entertain (not very often)—all Red Cross and Army people. They get N.A.A.F.I. rations and live very well, but it is difficult to live on the land as I am trying to do. We are in the middle of the "small rains," and so every day is thundery and miserable for two or three hours. The city stretches for miles through eucalyptus forests. Transport is very difficult; there are quite a lot of old Italian lorries, vans and cars, but no spare parts or tyres ! The British Military Mission have headquarters on one of the outskirts of town, opposite the Air Port, about six miles from town centre. I was fetched out there to liunch last week ; the car was late in arriving and had broken down earlier ; it broke down again outside the town, so another Army car took us on to the transport depot and the broken-down car was left on the hill in the charge of a little Ethiopian boy. Last night two of the men came to my house and, about midnight, tried to start the car off. There was nothing doing and we had to leave it to be towed out this morning ; we walked easily ten miles home !

The British Legation is further out on the north road—set in lovely parkland with enormous avenues—they have King's African Rifles on guard at the gate. I wish you could see what I can see now ! The next house is having a lunch-party ; the Ethiopian guests have arrived and, on the verandah, stand the servants of guests ; they are draped in the white native dress like Roman togas. As other guests arrive the servants bow to the ground and kiss the feet of any very elevated person. I hired a little "Ballila" car for the first month, but it broke down on me and nearly deposited me over a precipice—so now I have to hire a "gharry" wherever I go—awkward if it rains ! The Ethiopian gharry is like the seat from a car with two trap wheels and old motor tyres ! The woodwork is sometimes red or blue and the horse is always very thin, tired and raw with sores ! On my way to town we swerve round corners, slide down the hills, and usually the horse has to be dragged up the steeper ones. The natives have no road sense, so the driver usually shouts "*Mangad, mangad, mangad,*" which means "gangway." I often feel like shouting with him. In the less frequented spots he shouts to the horse, "*Hade*" ("Go.") He also shouts to the other drivers of garries, so progress is anything but peaceful.

Addis Ababa is nothing like a town ; all the shops are Greek, Armenian, Arab or Indian bazaars ; there are several cinemas, very bare and poor, and the films are very old ; "The Citadel" is one of the newest ones they have had. The few hotels are terrible ; at one the proprietress (? French) had a fight with a lady guest. All the crockery came out of the window and they chased one another through the streets, cheered on by several American signallers. The hospital accommodation is hopeless, and the Red Cross and Friends' Ambulance have plenty to do. An Ethiopian ignoramus, who knows nothing about drugs, is in charge of medical stores, which, of course, is housed about eight miles out of town ! It often means four or five trips out and a free fight for the Friends' Ambulance to get any stores, even those for which they have a signed chit. On the other hand, the baby son of a rich Ethiopian was ill with what father said was pneumonia. Father was issued with one hundred and fifty M. & B. tablets ! These tablets can only be procured in town at black market (3*s.* each) ! Aspirins are about 6*d.* each.

The Friends' Ambulance unit has a house not far from mine. Dr. Vesey, the London Senior in charge, brought round a Guy's man the other day (Griffin). I don't often see them ; they are so busy, but I sent them a cleft palate, a mastoid, and an incomplete abortion yesterday ; they probably wouldn't all arrive at hospital, because they put it off until they are nearer death's door and can hardly crawl there ; also they try a few Italian Ethiopian witch doctors before going to hospital ! If a baby doesn't suck well, they go to the market and find a doctor who comes and rips off its

uvula by hand! If a child is teething and seedy he removes the first teeth and says the child will be better now! Quite often the child is better off in Heaven. New babies have lumps of (?) butter rammed down their throats—yes, even by educated mothers!

Oh, dear, it is pouring with rain now, so no one will come to tea! I have no wireless or amusements of any sort. Really one needs to be a missionary to be happy here.

Yours, etc.,

CECILIA FURNISS.

Sport

Cricket

GUY'S *v.* METROPOLITAN POLICE.

(*Played at Imber Court on July 16th.*)

Score: Guy's, 131; Metropolitan Police, 110 for eight wickets. Result: Draw.

After sundry travelling difficulties an augmented Guy's side went in to bat at 3.15 p.m. Wickets soon fell and the Hospital total read 62 for eight. Thompson and Ray alone having distinguished themselves with 19 and 24 respectively. At this juncture Carton-Kelly joined Alderman and proceeded to demonstrate the qualities of the short handle on this occasion as the "long" was not available. He left with 32 to his credit, when Shaddick joined Alderman to carry the score to 131 before he was defeated (Alderman 23 not out).

The Guy's opening bowlers made but little impression on the early Metropolitan Police bats, but the scene was soon changed when Shaddick and Saunders came on. The London Hospital player took four for 25 and Saunders three for 29, but they were, however, unable to dislodge Green and Coles at 8 and 10 respectively, and so the match was drawn.

Team.—E. G. Murphy, L. D. Carton-Kelly, E. W. R. Alderman, D. R. S. Saunders, G. Thompson, D. J. Sheerboom, A. E. Trist, E. W. Graham, K. G. Pritchard, R. A. Shaddick, E. J. Ray.

GUY'S *v.* ORPINGTON C.C.

Result: Won by eight wickets. Orpington, 87; Guy's, 112 for two.

A welcome return to H.O.P. after many weeks' absence found the Guy's side stiffened by McNeil and his exemplary fielding, playing Orpington C.C. Murphy was unable once again to determine on which side the coin would fall and so Guy's took the field. Pierce was the only opposing batsman able to cope with the assorted Hospital deliveries, raising 23 of his side's 87 runs. Alderman, Thompson and Trist shared the bowling honours.

Pritchard's wicket-keeping during the greater part of the game made the clowning of Chaplin seemingly fade into mere mediocrity.

Guy's had little difficulty in achieving the runs due mainly to a well-played innings by Murphy, who was still at the wicket at the close with 56 to his credit. Later Graham helped him with 23 not out.

Team.—E. G. Murphy, L. D. Carton-Kelly, E. W. R. Alderman, G. Thompson, A. E. Trist, K. G. B. Pritchard, E. W. Graham, D. P. Nicholson, R. D. Rogers, R. Webb and D. J. McNeil.

GUY'S *v.* BUCCANEERS C.C.

Result: Won by four wickets. Buccaneers, 117 for nine; Guy's, 118 for six.

Guy's won the toss and Murphy, ignorant of the fact that a new ball was to be used for both innings, sent the Buccaneers into bat. They started well, but seemed unable to get on top of the steady Guy's attack, and even Parker compiled his 73 slowly before being l.b.w. However, it was he who was mainly responsible for his side being able to declare at 117 for nine after two hours twenty minutes batting. Trist, Alderman and Carton-Kelly, who each got two wickets, coupled with the fine wicket-keeping of Pritchard, who was the instrument of dismissal of four of the opposing side, gave the Buccaneers little chance to expand.

The Guy's innings opened disastrously, Murphy, Thompson, Boyd and Alderman being back in the pavilion with only 18 runs on the board. Hanworth, however, stayed to make a useful 26, but due to the initial setback Guy's had got well behind the clock.

Graham and Sheerboom with 32 not out and 19 respectively soon set matters to right, and it was finally left to Graham and Trist to win the game in the last over.

Team.—E. G. Murphy, L. D. Carton-Kelly, E. W. R. Alderman, D. C. Boyd, G. Thompson, D. J. Sheerboom, A. E. Trist, K. G. B. Pritchard, E. W. Graham, R. W. Hanworth, H. E. R. Chew.

Swimming Club

On July 8th against Bishops Stortford College. Drawn. 23½ points—23½ points.

The result of this match was disappointing as we considered the team as unbeatable, but, without the help of both breast-stroke swimmers, we did well to make it a drawn match. This could not have been possible without D. J. Gray, who, as usual, competed in nearly all the events. At the moment this is very much a one-man team, and in order to win the rest of the matches it is most important that everyone should do their utmost to keep in training, and I am sure that keenness will be well rewarded.

RESULTS.

100 *yds. Freestyle.*—(1) D. J. Gray; (2) B. M. Gray; (3) Bishops Stortford; (4) Bishops Stortford.

50 *yds. Freestyle.*—(1) Bishops Stortford; (2) B. H. Pickard; (3) Bishops Stortford; (4) R. G. Iliffe.

50 *yds. Breaststroke.*—(1) Bishops Stortford; (2) E. L. Leiser.

50 yds. Backstroke.—(1) D. J. Gray; (2) B. M. Gray and Bishops Stortford; (4) Bishops Stortford.

Diving.—(1) D. J. Gray; (2) Bishops Stortford.

Medley Relay.—(1) Bishops Stortford; (2) Guy's.

Freestyle Relay.—(1) Guy's; (2) Bishops Stortford.

Water Polo.—Lost 1–6 goals.

Team.—B. H. Pickard, D. J. Gray, B. M. Gray, R. G. Iliffe, R. A. Dean, D. Walker, E. L. Leiser, J. M. Pugh.

Hospital Information, etc.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

April, 1944.

Surgery.—*F. R. S. Knight, *E. G. Wright.

Pathology, Bacteriology and Forensic Medicine.—*W. H. Lillywhite.

* Have completed the examination.

PRE-MEDICAL AND PRIMARY EXAMINATION.

July, 1944.

Materia Medica, Pharmacy and Pharmacology.—H. Freeman, J. Wotton.

CONJOINT BOARD.

FINAL EXAMINATION.

July, 1944.

Midwifery.

J. P. M. Bensted	*H. J. Lewis
J. S. Ebsworth	J. N. Micklem
*G. J. Haas	B. G. P. Oakenfull
W. T. Harrett	J. M. Thomas
*C. C. Kennedy	C. C. Vidot

Medicine.

*A. M. Emrys-Roberts	*R. G. Lomax
*J. S. Hodgson-Jones	*D. J. Morton
E. A. Humphrey	*H. W. Palmer
*B. C. Lee	*G. M. Turner

Pathology.

D. J. Chapman	R. P. C. Macdonald
S. Davis	R. R. W. Nichols
E. L. Dutton	J. S. Smith
N. R. Fenton	C. C. Vidot
M. B. King	R. G. Walton
*C. C. Kennedy	

Surgery.

P. K. A. Andrews	N. R. Fenton
F. J. Aumonier	*G. J. Haas
M. A. Barker	H. A. Lane
J. P. M. Bensted	*H. W. Palmer
R. G. L. Brittain	P. F. Pearson
B. Clarke	B. G. P. Oakenfull
J. S. Ebsworth	J. S. Smith

* Have completed the examination.

Papers by Guy's Men

Braithwaite, J. Vernon. The modern diagnosis and treatment of infantile pyloric stenosis. *Med. Pr.*, 1944, **212**, 36.

Close, H. G., and Another. Case finding for Mass Radiography. A report on 500 Selected Cases. *Lancet*, 1944, i, 653.

Charles, G. F. State Dental Service. *Brit. Dent. J.*, 1944, **77**, 29.

Cutler, Robert. Beveridge—and the future of Orthodontics. *Dental Rec.*, 1944, **64**, 132.

Cutler, R. Progress of Acrylic Conservative Technique—an evaluation of its present scope. *Brit. Dent. J.*, 1944, **77**, 1.

Erskine, David. The trend of Antisyphilitic treatment. *Brit. J. Ven. Dis.*, 1944, **20**, 73.

Gardiner, H. Diaphragmatic hernia with torsion of stomach and acute obstruction. *Brit. Med. J.*, 1944, ii, 114.

Hallpike, C. S. Research in Otology. *Brit. Med. Bull.*, 1944, **2**, 119.

Hallam, J. W., and Another. Modern phosphorus caries and necrosis. *Brit. Dent. J.* 1944, **76**, 321.

Hart, M. C. Congenital absence of numerous permanent teeth. *Brit. dent. J.*, 1944, **77**, 41.

Hill, T. Rowland. Diagnosis in spinal cord injury. *Practitioner*, 1944, **153**, 45.

Howitt, Frank. An industrial rehabilitation centre. *Brit. Med. J.*, 1944, ii, 52.

Ingram, P. C. P. Treatment and prognosis of Gonorrhœa in the Female. *Med. Pr.*, 1944, **212**, 56.

Jacoby, N. M. A scheme for the prevention of cross infection in children's wards. *Arch. Dis. Child.*, 1944, **19**, 26.

Johnson, F. K. Dentistry during the Abyssinian Campaign: an account of a fortnight's tour at the front. *Brit. Dent. J.*, 1944, **77**, 44.

Loader, S. A. The trend of plastics in dentistry and surgery. *Brit. Dent. J.*, 1944, **77**, 39.

Matthews, E. A new approach to full denture construction. *Brit. Dent. J.*, 1944, **76**, 261.

Peatfield, F. H. W. A mobile dental unit. *Brit. Dent. J.*, 1944, **77**, 47.

Pendred, Vaughan. Fifty years' experience in Medicine. *West London Hosp. J.*, 1944, **49**, 14.

Rogerson, C. H. Narco Analysis with Nitrous Oxide. *Brit. Med. J.*, 1944, i, 811.

Tregarthen, G. G. T. The Anodic Treatment of Aluminium and its Alloys for use in the Mouth. *Brit. Dent. J.*, 1944, **76**, 300.

Toussaint, C. H. C., and Another. The Problem of Early Diagnosis in Pulmonary Tuberculosis. *Post-Grad. Med. J.*, 1944, **20**, 143.

Worster-Drought, C. Cerebro-spinal Fever. Diagnosis. *Post-Grad. Med. J.*, 1944, **20**, 99.

Worster-Drought, C., and Others. A form of familial presenile dementia with spastic paralysis. *Brain*, 1944, **67**, 38.

Wright, G. Payling, and G. M. Clark. Schick reactions in recently confined women and their infants. *Brit. Med. J.*, 1944, ii, 146.

Change of Address

G. K. Reeves, M.R.C.S., L.R.C.P., 66, Upper Tulse Hill, S.W.2. Tel.: Tulse Hill 2756.

Marriages

WHITE—KINDER.—On July 1st, 1944, at St. Thomas's Church, Southborough, Kent, Surg.-Lieut. Douglas A. White, R.N.V.R., to Audrey Joyce Kinder.

Deaths

ROBERTS.—On June 19th, 1944, Theodore Essex Roberts, M.R.C.S., L.R.C.P., of Mercier Road, Putney.

EDS. {D.R.S.S. J.P.M.B.

GUY'S HOSPITAL GAZETTE

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PASSIM

A COPY of the Goodenough Committee's report has recently come into our possession through the courtesy of one of the members of the staff and we have studied it eagerly. The Report deals comprehensively with the future of medical education and puts forward many suggestions for improvements and for changes in the present system.

The general principles of the Report are set out in the first few pages, the keynote to them being that unsuitability shall be the sole barrier to anyone desiring to study medicine. In addition to this, the Committee urges that every student should enjoy a university education on broad and liberal lines, though it does not specify whether these lines should be on subjects other than medicine. The independence of medical schools in academic matters is to be maintained, but there are many suggestions for a change of approach to the system of teaching. All teachers are to undergo a special training in that art and they are to be fully remunerated for their teaching duties; in addition to this, the system of medical education is to be radically altered, with an increased bias towards fundamental principles and a drastic pruning of technical and theoretical detail.

The Report goes on to deal with these points in detail. On the facilities for clinical instruction it is suggested that the present system be expanded to deal with the increased number of students that are expected; the unit is to be the Medical Teaching centre which incorporates hospitals, clinics and out-patient departments, laboratories and so on under a central administration. The aim of these centres is to care for the sick and to promote education and research; and it is stressed that the former should not be allowed to outweigh the latter, as has been the tendency hitherto. The staffing of these centres is also considered in the Report, and it is suggested that each clinical division should be under a whole-time academic head, who shall co-ordinate the work in that department and take part in the teaching. All other teachers in the centre shall be paid in respect of duties defined by the medical school, and a special clause is added with regard to the junior teaching staff, who are to receive a larger remuneration than is at present the case together with family allowances, travelling scholarships and other such luxuries.

As has been already mentioned financial considerations are no longer to influence the opportunity of anyone taking up medicine as a career, and to combat this difficulty there is to be a system of Exchequer grants to medical schools. There is, however, a proviso to this clause which will possibly cause perturbation in certain quarters, and this is that, in order to qualify for these grants, the medical school must take women students up to one-fifth of its total numbers. A further excellent suggestion is that all unsuitable students should be "weeded out" by the end of the first year.

In addition to cutting out all superfluous detail, the Committee recommend that Social Medicine, Child Health and Psychiatry should feature more prominently in the medical curriculum, whereas special departments should only teach material necessary to the general practitioner. Specialist training would be confined to post-graduate teaching, and general practitioners would be able to keep up to date by establishing more intimate contact with their local consultants.

Finally, it is proposed that the examination system should be modified to conform with the new curriculum and a course of intermediary internal examainations are suggested to offset the brunt of Finals. After a student has passed his final qualifying examination, and before he is admitted to the Medical Register, it is proposed that he should serve as a junior house officer for a year, six months in the Medical and Surgical wards respectively.

On Wednesday, August 9th, at a meeting of the Governors and Medical Staff to discuss the rebuilding of the Hospital, the architect put forward his plans. We are hoping to be able to publish an article on these plans together with photographs of the proposed buildings.

According to the *Daily Telegraph* of August 11th, 1944, the result of the B.M.S.A. questionnaire on the National Health Service shows that out of 2,588 students the majority consider that the country would benefit from a National Service. This makes interesting reading when compared with the results of the B.M.A. questionnaire, which showed that the majority of qualified doctors reacted unfavourably.

Although the number of replies received from students hardly warrants a definite conclusion as to their state of mind on this matter (many students at Guy's were quite unaware that any questionnaire had been arranged owing to misunderstandings about distribution of the question-sheets) it is surely unfair to take no notice at all of their opinions.

We are very glad to hear that Mr. John Winston is back again in the secretarial chair in the Medical School office. We hope that he has thoroughly benefited from his rest at The Wildernesse.

Our photograph this week was taken at a special meeting of the Court of Governors when the grant from King Edward's Hospital Fund was announced.

People are urgently required to prepare the Rugger Ground at Honor Oak Park for the coming season.

An appeal has been made for fifty students to come forward to help on three successive Saturday afternoons; and help throughout the week would also be much appreciated.

Obituary

BEATRICE DORA FAGGE.

On July 12th, 1944, the death occurred, at her home in Lacey Green, of Beatrice Dora Fagge, widow of the late Guy's surgeon Mr. C. H. Fagge. But to old Guy's nurses Mrs. Fagge's death means something more, for they will remember her first as Miss Metcalfe, the tall, handsome Australian, with the dignified carriage and clever capable ways who became a lady pupil at Guy's Hospital in May, 1893. In those days the educated ladies who became lady pupils trained for one year only, and then were made ward sisters, and Sister Dora Metcalfe held the posts of Sister of the Accident Ward and other wards and departments until early 1899, and, during that time, as was the custom in those far-off days, she also studied massage and obtained the certificate L.O.S.

Then she married Mr. C. H. Fagge and settled down to rear a family in one of the large houses in St. Thomas Street. She became one of the representatives of the wives of the Staff on the Council of the Nurses' League, and from that moment her unfailing interest in the Guy's Nursing Staff—their comforts, their recreations, an their general well-being—never failed. A keen gardener and splendid tennis player herself, she equipped the tennis-courts at the Nurses' Cottage, Honor Oak Park, and encouraged tennis among the nurses; the Fagge Cup, which she presented to be competed for annually in tennis singles, stands a permanent memorial to her, but as an even greater memorial among those who remember her were her countless thoughtful acts to embellish and enrich the lives of the residents at Guy's. There were delightful musical evenings in her house which were enjoyed by many Guy's nurses and students; parties for progressive games—fashionable in those days; literary evenings; cycling expeditions—for those were the days when cycling had caught the popular imagination, and, above all, and through all, her gift as a perfect hostess.

One little memorial of her public spirited outlook she shared with Mrs. Lariston Shaw and Mrs. John Fawcett, when, between them, they prevailed upon the Borough Council to allow them to plant acacia trees in St. Thomas Street, opposite the Guy's residential houses.

The older generation of Guy's nurses will always remember Mrs. Fagge with an affectionate regard.

E. R.

War Surgery

A Lecture delivered at Guy's Hospital Medical School on Thursday, June 22nd, 1944.

By N. L. ECKHOFF, M.S., F.R.C.S., *Surgeon, Guy's Hospital.*

WHEN I chose the title for this lecture a few weeks ago I had in mind, as we all did, the second front. Since that time many of you have seen air-raid casualties here which, in the main, present the same problems as battle casualties; as there has been a gap of two years during which we have not had many casualties I thought it was appropriate to review the situation, especially as many of you will no doubt shortly join the Services.

It is appropriate that in the last few weeks there have been several publications from surgeons giving us the benefit of their observations during the North African campaign, and there is an excellent book published by Mr. Ogilvie, entitled "Forward Surgery," which I strongly recommend you to purchase.

Sorting.—The first problem that presents itself when casualties arrive is that of sorting. Here the most senior man on duty usually undertakes that job and in warfare people are detailed for that purpose. The reason we choose the most senior man is because we feel that while the actual surgery of war casualties can well be delegated, the senior man is possibly more quickly able to judge which cases require immediate surgery and which can do well with delayed surgery. The group that require urgent operations are abdominal cases, cases of severe hæmorrhage, of severe mangling of the limbs, of suction or tension pneumothorax, cases with bad respiratory obstruction, and bad burns.

The next group are cases that can wait for a few hours for operation. These are instances of joint injuries, compound fractures, large flesh wounds and large foreign bodies. Thirdly, there are those that can be sent away to a special centre within a short time, if one is available: injuries of the head, the spine, the orbit, and facio-maxillary cases.

The fourth group are those which can be sent away to some other centre, even if this is not very close at hand: small flesh wounds, simple fractures and minor burns.

Resuscitation.—Having made a decision as to classification the next item of importance is resuscitation. You all know that the main basis of resuscitation is rest, warmth, fluids and morphia. You know also that we distinguish between primary shock and secondary shock. Some are admitted in a condition of shock, which responds well to treatment and that is called primary shock. There are others in which the shock continues for several days and that condition is commonly called secondary shock.

I will not attempt to deal with the theories of shock to-day, and I am not sure whether a distinction between primary and secondary shock is of real pathological significance, but for clinical purposes we attempt to divide cases into these two categories. Nor need I delay you long about the signs of shock. The patient is cold, clammy, with sweaty forehead, cold limbs, short respirations, thin pulse, oliguria, sometimes vomiting, low blood pressure and low pulse pressure, although this is by no means a constant finding. Variations in blood pressure and pulse pressure have puzzled authorities (like Dr. Grant here in the early "blitz" period) and the most extraordinarily contradictory observations were made, but, for the time being at any rate, I think you will find the pulse pressure is the most valuable indication of the state of shock. A blood pressure below 100 m.m. indicates a fairly severe degree of shock.

The degree of shock can be rather closely related to the loss of blood, remembering always that people can suffer from severe shock without loss of blood at all. A person can lose one pint of blood without showing any shock; he can lose two pints, showing a mild degree of shock; but with a loss of four pints shock is profound.

The most useful piece of information from the North African campaign is that transfusions can be given not only much more rapidly than we thought possible, but also in much larger quantities. It is often correct to get the first pint into the patient in five minutes, and it is considered desirable to get the total fluid replacement made within about four hours. Some patients have had ten pints of intravenous fluid

within the first 24–48 hours. If the patient does not respond to the first pint of fluid you must not be afraid to continue giving it. You may turn the scale in his favour by being rather dramatic in your treatment.

Remember that during the state of shock all the organs of the body suffer and that infections flourish in devitalised tissue; therefore during the state of shock everything is going on to the patient's disadvantage.

There is one further point of great importance. Absorption of morphia is retarded in the presence of shock, so if a person who has received ¼ grain of morphia is admitted to hospital and appears to require more morphia he may well be given a second dose. He will then be treated for shock, and as he responds the absorption of this total amount of morphia proceeds rapidly; it may well be found that he has had an overdose, so that care must be exercised in giving a second dose until the circulation has been whipped up and he has slightly improved.

One other important observation: beware of using artificial heat in the form of electric cradles for shocked individuals. There is abundant evidence now that overheating a shocked person can do him a great deal of harm. Cold, clammy skin is Nature's reaction to loss of blood, etc., and if peripheral vaso-dilatation is induced before the body fluids are built up it is clear that the vital organs will suffer a still further depletion, much to their detriment. For heating purposes, therefore, rely on heating by blankets or hot bottles, but be very cautious in the use of electric cradles.

X-rays.—I need not say very much about the use of X-rays. Obviously X-rays will be used to only a limited extent in war casualties, partly because X-ray machinery is not always available and partly because the number of casualties being great, everybody is over-worked. They will be required in cases of wounds with severe bony injuries or an underlying foreign body. A foreign body may enter in the buttock and you will want to know whether it has gone up towards the abdomen or downwards towards the leg. Use X-rays, then, in selected cases for special purposes.

Immobilisation.—Many war casualties require some form of immobilisation. There are a few methods which have been found useful which I should bring to your attention. Remember that unpadded plasters are completely forbidden, the reason being that so much swelling occurs after the injury that an unpadded plaster is always dangerous. In patients with a fracture and a burn there is a double danger. All patients with burns develop severe subcutaneous œdema and patients with fractures develop swelling deeper still. The combined effect obliterates the circulation if an unpadded plaster is applied.

In war wounds plasters are all padded and also all split, and this is very important if a patient is to be transferred to another hospital.

In the last war Thomas's splint was introduced and found extremely useful, and it has been exceedingly useful in this war, but its usefulness has been increased by what is known as the *Tobruk plaster*. Fixed strapping extension is applied to the lower part of the leg, with an anklet of felt, and the leg suspended in the usual way, and the wound suitably dressed after treatment. The thigh and leg and the Thomas's splint are then held together by encircling bands of plaster-of-Paris, suitably moulded to keep the ring of the splint under the trochanter. This prevents the splint from riding up during transport and generally fixes the limb in a safe and comfortable manner for transport.

Another new type of plaster which is very useful for transport is the *thoraco-brachial box*; where it is necessary to immobilise the upper arm or shoulder-joint, instead of putting the patient in the more conventional abduction spica, the arm is placed at the side and the chest and arm are plastered all in one, leaving the forearm out. If there is an injury to the forearm a further splint can be applied. When the patient arrives at a more suitable hospital abduction can be introduced.

In head wounds it has been found very useful to put a plaster *head cap* over the dressing. You all know the great difficulties of getting an ordinary simple bandage to stay on a head. Therefore it is legitimate to throw a plaster-of-paris bandage over the dressing if the patient has to be moved, and this will not come off provided a few turns have been placed from above the external occipital protuberance to the region between the glabella and frontal eminence, with a few turns running from below the external occipital protuberance to above the frontal eminence.

I will not go into the problems of evacuation; those are the special worry of the senior man in charge.

Wounds.—I will remind you that contamination takes place almost at once and that infection is actually present in about six hours. In the North African campaign it was found that infections from organisms of the spore-bearing variety and the pyogenic variety occurred in a large majority of cases and were present remarkably early. The degree of infection will depend not only on the local resistance and the blood supply, but also on the number of organisms present in the wound; it also depends on the general health of the individual, the degree of exposure, the presence of excessive heat or cold.

Having treated shock and examined the wound and made the necessary diagnosis, clean the surrounding area very thoroughly, for which purpose you may use any mild antiseptic which happens to be available. I have frequently stressed the great value of plain soap and water, perhaps more to impress the importance of washing than the value of any particular antiseptic. People are inclined to dab the wound with a spot of iodine and think they have done something magical. This is not true, and iodine on the cut surface may do a certain amount of harm by coagulating protein. A piece of soap in your hand reminds you of the need to wash, and you should go on washing and washing round the wound, and, at the end, fill the wound itself with mild antiseptic, saline, or soap and water once again. There is no need to put strong antiseptic into the wound.

Having done this you proceed to the necessary operation. There has been a good deal of argument from the beginning of the war about *débridement*. The word was introduced a long time ago and does not mean anything more than "back cut," cutting open the wound, but the term has been used very loosely in this country to indicate various degrees of excision. "Wound trimming" and "wound revision" are probably better terms.

Experience has shown that excessive excision of the wound is not necessary. But it is necessary to lay open the wound widely, and therefore to extend the size of the surface wound by what I call the "back cut." You must try to convert the wound into a saucer-shaped cavity. Excessive excision of skin is nowadays considered to be *sabotage*. Excise those parts which are going to die; trim the rest only; excise and make relieving cuts in the deep fascia; excise portions of muscle which you judge will die; then go deeper with close observation of vessels and nerves; study the damage to the bone, if any; remove the foreign body if it is large or can easily be removed, but do not prolong the operation to search for small foreign bodies; then spread in up to 15 gm. of sulphonamide powder; if penicillin is available you might decide to use that; then pack lightly with vaseline gauze and immobilise in plaster-of-paris. That is the general routine treatment of all wounds.

The special points I would emphasise are: do not remove too much skin, make ample incision in the skin and deep tissue, provide drainage, pack lightly and immobolise.

Primary suture has virtually no place in war surgery. In the last war prople tried it from time to time and in this war it is being experimented with under special conditions, but the time has not yet arrived for it to be used widely. Secondary suture has a very definite place; when the immediate period of infection has passed the skin edges can often be brought together after suitable undermining by secondary suture, thus shortening the time of invalidity quite considerably. For wider gaps early skin grafting is to be encouraged.

Special Wounds.—The through-and-through bullet wound does not cause much anxiety. The mere fact that the bullet has gone in and come out means, usually, that it has taken with it any fragment of clothing that may have been indriven. These cases do well with sulphonamide sprayed into the wound, a dressing and a splint.

Phosphorus Wounds.—The dangers in wounds due to phosphorus are damage to kidney and liver, and it is extremely important to eliminate every trace of phosphorus immediately. If the wound is superficial it is a good idea to plunge the patient nto a bath and wash it all off. It is then wise to turn out the lights and inspect him in the dark. Having removed all large particles of phosphorus you may attempt to neutralise smaller quantities with 2 per cent. copper sulphate or 1 per cent. sodium bicarbonate. If these are not available use potassium permanganate or hydrogen peroxide. In the case of a deep wound proceed to excision, remembering that no oily dressings are to be used. Suitable drainage with Carrel tubes added should be arranged, and the patient should be given plenty of glucose to ward against possible liver damage.

Infected Wounds.—If patients do not come to hospital within the first six hours they have to be treated rather differently. Excision, as such, does not take place at

all. Remove rather gently such tags of tissue as are thought to be completely dead; use the back-cut once again to increase the size of incision; insert drainage; remove foreign bodies if they are easy to find; use such sulpha-drugs as are available or of choice. Excision is not advisable at this stage because infection has already started, and in excision new tissue is opened up which only spreads the infection.

Mine Wounds.—These form a very specialised group. Some have limbs blown off immediately, but in others the limb might not appear to have suffered so badly, but, on examination, extensive comminuted fractures are found extending right up the limb, so much so that amputation may be necessary although the superficial damage is not very great. Remember there is a much greater potentiality towards infections such as gas gangrene because of the extensive damage to the tissues underneath the skin. If amputation is not immediately necessary such a case is treated by adequate incision, vaseline gauze and a padded plaster splint, as before.

Wounds of Bones and Joints.—These come into the early operation series. It is necessary to be especially careful about primary cleansing. If a joint is opened it should be washed out with a mild antiseptic such as flavine, eusol or something similar. Having washed out the joint carefully and cleaned out the material that has been indriven, remove small fragments of bone, close the synovial membrane, do not close the capsule nor the skin, pack with vaseline gauze and immobilise. If the wound is serious ankylosis must be anticipated and the wound placed in a suitable position. I need not tell you the optimum position for each joint. This is something you should know already.

Arterial Injuries.—These form an interesting group. In any big collection of casualties there may be one or two cases of injury to the big vessels. If a big vessel is completely ruptured the most striking thing is the small degree of hæmorrhage that takes place because of Nature's remarkable method of dealing with it. The end contracts and retracts and is quickly sealed off. A certain French surgeon makes a point of cutting across the renal pedicle without clamps, after which he plunges a pack in the cavity and goes outside to smoke a cigarette, much to the consternation of the people watching. He comes back, removes the pack, and the bleeding has ceased. I do not advise you to try this. But a partial injury is a very grave matter indeed. The vessel goes on bleeding indefinitely. If it is a major artery the patient will die if the blood escapes to the surface. If the blood cannot escape an arterial hæmatoma will form, which will begin to pulsate and may develop into an arterial aneurysm. But in the early stages, when the hæmatoma is forming, the artery is pressed upon and the limb deprived of its blood supply. In these vascular injuries the tourniquet is a necessary evil. As Mr. Ogilvie puts it, "it is always evil and seldom necessary." This I would emphasise again and again because a tourniquet can produce most serious damage to nerves by local pressure and to the whole limb from temporary ischaemia.

In addition to direct injuries to blood vessels—complete division and partial division—a condition of arterial spasm is very often induced by injury. We had an interesting case of that sort in a boy who had a small wound over the femoral artery, pulsation below being absent. On exploration (Mr. Wass) the femoral artery was completely contracted at the site of the injury, although the artery itself was not perforated or damaged in any obvious way. In this case we decided to ligature and divide the artery. There has been a great deal written about traumatic arterial spasm. It is a little difficult to say whether it is wise to ligature and divide the artery; some people think it is, some do not. It is sufficient in some cases to inject a little novocain around the artery, in others a peri-arterial sympathectomy may be sufficient, but the purpose of dividing the artery is to interrupt all the sympathetic fibres and produce vaso-dilatation below.

One must discuss the interesting problem of whether the vein should be divided. This is another point about which there has been controversy. Some people said that the blood supply of the limb—or the future of the limb—was better if the vein was ligatured at the same time. Others contested this and the modern view is not to ligature the vein unless it happens to be injured, in which case it may well be ligatured. If arterial ligature becomes necessary gangrene is likely to occur in a much higher percentage of cases than one might think. Ligature of the brachial artery or the femoral artery is followed by gangrene in 25 per cent. of cases in war casualties in young men. Ligature of the popliteal artery is associated with gangrene in 41 per cent. of cases. Ligature of the common carotid or internal carotid is associated with

softening of the brain in 25 per cent. of cases. Ligature of the lesser limb vessels or the external carotid is not faced with these dangers.

Amputations.—In war surgery amputations with flaps sutured together are completely forbidden. Guillotine amputations are not popular in most circles so as a compromise it is best to carry out the amputation considerably below the site of election, to outline the flaps, leave the wound widely open, pack with vaseline gauze, and immobilise. Here, again, secondary suture after a few days or a week has a very important place. But do not carry out primary suture.

Abdominal Wounds.—These form an interesting group and the mortality is still remarkably high. For wounds of the colon it is 50 per cent. or more, for wounds in the small intestine in the neighbourhood of 33 per cent. Diagnosis may be difficult. If a piece of metal has entered the front of the abdomen the doctor is likely to think of abdominal complications quite early, but if it has entered the back either in the loin or in the region of the buttocks, he may not think of it quite so soon. Wounds in the buttocks are especially dangerous because the metal may enter the pelvis, damage the large bowel, the rectum or the bladder, and gas gangrene is also extremely likely to occur. If there is any doubt in a particular case as to where the bit of metal has finally ended its course, there are certain signs which will make the doctor suspect injury to the abdominal viscera. These are a rising pulse rate with guarding of the abdomen which is spreading, with tenderness, and with silence on auscultation. These are the most important signs.

The special points in treatment before operation are fluids intravenously, not per mouth or per rectum. At operation if there is a wound in the back, explore that first. It is a strange thing that if a patient has an operation on the abdomen and is turned over for the back to be explored the blood pressure falls in a startling manner, whereas if the back is explored first, and he is then turned over, the same thing does not happen.

The wound must be enlarged, and you must find out exactly how far the foreign body has penetrated, and if you are at all suspicious about it having entered the peritoneum do not hesitate to explore that as well. If the peritoneum is opened every inch of the intestine must be searched in order to make certain that injury is excluded. Quite small injuries may occur in the small intestine and the mere finding of one perforation does not mean the job is ended, for multiple perforations are exceedingly common. If there is one perforation only it can be dealt with simply, if there are multiple perforations resection may be necessary. If the wound is of the colon it is absolutely essential to establish colostomy by bringing out the loop, or it may be necessary to perform proximal colostomy. Likewise, if the wound is of the rectum, colostomy is absolutely essential with posterior drainage of the pelvis; if necessary, removing the coccyx.

Hæmorrhage from the liver can usually be dealt with by some form of local pressure, preferably not by gauze because when it is removed it may continue to bleed; one can occasionally suture and occasionally sew omentum into the gap. A damaged spleen is usually removed. Injuries to the kidney need not necessarily mean removal. Drainage of a wounded bladder is just as important as drainage of the large bowel.

In abdomino-thoracic injuries the problem is method of approach. Sometimes it is possible to approach through the chest and deal with a large part of the abdominal injuries through that route, but an abdominal incision may also be necessary. Crushing of the phrenic nerve is useful in suture of wounds of the diaphragm.

One thing that has come out of the North African campaign is that post-operative treatment of abdominal cases is very important. It is advisable in intestinal injury to set up duodenal suction forthwith by means of a narrow rubber tube of Ryle's (or similar) pattern going well into the duodenum, which must be kept in for many days during which time intravenous fluid is given. It has also been discovered that these patients do not travel well, which is, to my mind, rather astonishing. I had always understood that abdominal cases could well be moved after a few days. This may be true in civilian surgery. I had also understood that head cases do not move well. Before the war the London County Council refused to receive a head case from any other hospital. Both these views seem to have been upset because they tell me that head injury cases travel quite well whereas abdominal cases travel extremely badly and must be kept for at least a fortnight after operation.

Chest Wounds.—At the forward centres do very little; do not explore the wound or open the pleural cavity if it can be avoided. It may be that hæmorrhage from

intercostal vessels will have to be dealt with and the same principles of cleaning the surface wound must be applied. Avoid opening the chest if possible and send the patient to a suitable chest centre.

There are two varieties of emergency which have to be dealt with. One is open pneumo-thorax which is best dealt with by a pad or an ordinary field dressing over the wound, or at most by a few sutures in the skin over a roll of vaseline gauze or some suitable material. The other is tension pneumo-thorax which arises from a small wound in the lung producing mediastinal displacement, and increasing dyspnœa and is relieved by putting a hollow needle into the second space in front and allowing the air to escape and bubble through water. Apart from these two special emergencies there is very little to do at the forward centre. Hæmothorax may become a problem if the patient is kept longer, but, as a general rule, he should be transferred as quickly as possible.

Cardiac tamponade is another problem which, again, may have to be relieved by aspiration of the pericardium.

The subjects I have not dealt with are head and face injuries and burns. You have probably heard so much about burns that I will not go into that to-day, but I have a few lantern-slides of face injuries which may interest you.

The first is a case of compound fracture of the jaw, with severe facial lacerations from a grenade explosion. After very thorough cleansing with soap and water the fracture was first inspected and all completely loose fragments of bone removed, as well as loose teeth and teeth in the line of fracture. It was then possible to suture the mucous membrane completely, taking especial care to adjust the vermilion border of the lip to the nearest millimetre. Subcutaneous tissue was sutured with catgut and skin with fine interrupted sutures, placed close to the skin edge and about 2 mm. apart. *No skin was removed*, but drainage provided through a convenient gap at the most dependent part. Later the jaw fragments were fixed, making use of pins for the posterior edentulous fragment, and bony union took place, in spite of the severe fragmentation and some loss of bone. The soft tissue wound healed excellently.

In the second case the injury (from bomb damage) was similar except that there was considerable loss of skin and mucous membrane, and approximation would have been foolhardy, owing to the distortion that would have ensued. Therefore, after wound trimming and similar attention to the teeth and bone as above, the mucous membrane was deliberately sewn to the skin, thus covering over the exposed bone and cheek tissues, but creating a fistula into the mouth. In three weeks all was cleanly healed. The defect, about the size of a crown, was later repaired by a tube pedicle from the chest and the jaw united with a bone graft. In this case we went out as a mobile team from the centre to the incident in London.

The third case did not arrive at the special centre until many days after the accident, which was a mine injury. The left arm was blown off and the eyes damaged, but, in addition, the face was peppered with hundreds of tiny pieces of explosive and dirt. There was a compound injury to the jaw rather similar to the other two cases. Although the arm was well treated by amputation and the eyes received attention, very little had been done to the face. The wound had not been properly cleansed, but a few silkworm gut stitches had been thrown across the gap in the lip. Infection was so gross that these had to be removed as soon as he came to us and the lip fell apart. If only a little careful cleansing had been applied at the begining, I believe it would have been possible to suture the wound in layers, leaving room for drainage. In fact, after some months, it was necessary to reconstitute the original wound and approximation was quite easy. Similarly, if care had been taken to remove as many pieces of flint as possible at the start, he would have had much less tattooing of the face. He subsequently required a bone graft.

In facial injuries clean thoroughly, do not excise skin, remove only completely loose fragments of bone, suture in layers with fine stitches, providing drainage, but, if the gap is large, suture skin to mucous membrane or pack the wound open. Remove all dirt with a wire brush or curette and pick out all embedded foreign bodies. If possible, obtain the services of a special centre as early as possible.

REFERENCES.

Blackburn, G. *Lancet*, 1944, **1**, 361.
Law, W. A. *Lancet*, 1944, **1**, 425.
Ogilvie, W. H. *Lancet*, 1944, **1**, 556.
Trueta, J. *Lancet*, 1944, **1**, 651.

Photo by Benson's Press Service

Reading from left to right :—

Standing : Professor T. B. Johnston (Superintendent), Lt.-Col. R. W. Barclay, Mr. T.B. Lees Read (Clerk), Sir Hugh Lett, Lord Nuffield, Hon. G. Fortescue, Mr. J. E. Humphery, Sir Arthur Hurst, M.I. John Roberts, Mr. Arthur Owen, Sir Herbert Grotian, Mr. Oliver Watney, Mr. L. Gluckstein, Sir George Barstow, R. C. Nesbitt, Mr. G. Munro Kerr, Maj.-Gen. John Hay Beith Mr. W. Shand, Mr. F. J. O. Prescott, Sir George Cooper, Mr. H. L. D. Walston, Sir Ulick Alexander, Mr. C. J. Conway, Sir Sidney Clive, Sir Patrick Ashley Cooper, Mr. Oliver Hoare, Mr. J. A. Rank, Mr. Granville Sharp, Sir Herbert L. Eason, Mr. A. C. Gladstone.

Sitting : Sir Edward Peacock, Lord Queenborough, Mr. A. Wilson Filmer, Lord Rennell of Rodd, Lt.-Col. Eric Waley, Sir Edward Reid,, Mr. W. E. Stuart-Menteth.

Correspondence

DYSENTERY.

To the Editor of the GAZETTE.

SIR,—I do not think I agree with Lieut.-Col. Thurston's definition of dysentery, nor would I accept the "Nomenclature of Diseases" as an authority on its classification.

Despite the latter, which appears to require modernising, "dysentery" is a syndrome rather than a disease, represented by colic, frequent stools, the passage of blood and mucus and tenesmus. The *disease* is ulceration of the colon, and any condition which will cause ulceration of the colon can give rise to the "dysentery syndrome"—malignant disease, for example.

The diagnosis "dysentery, clinical" should be only provisional pending a laboratory report; but it should always be extended by some further explanation such as "acute bacillary type" or "amœbic type."

I have never seen a case diagnosed as "dysentery bacillary exudate" which, as applied to a patient, seems to me to be meaningless. Is it not a product of disease rather than a disease? And speaking of exudates, Colonel Thurston will remember the hundreds, if not thousands, of cases of bacillary dysentery which were diagnosed *and treated* as amœbic, because macrophage cells were mistaken, even by experienced microscopists, for *E. histolytica*.

I do not like the name "dysentery protozoal amœbic." It is tautological. "Dysentery, (note the comma) amœbic" is sufficiently descriptive.

The type of malaria which may "ape" dysentery is the subtertian in those cases where schizogony occurs in the intestinal capillaries. But, surely, if a routine examination of blood and stools is carried out, as should be the invariable rule in areas where both diseases are endemic, only carelessness could cause the one or the other to be missed—remembering that in subtertian malaria schizonts are rarely seen in the peripheral blood and that their discovery there is of very grave import.

Another point to be remembered is that the bacillary form is a *febrile* disease in which toxæmia may be so profound as to cause death before a single dysenteric stool has been passed. It occurs in epidemic form. Amœbic dysentery, uncomplicated, is *not* a febrile disease and it does not usually occur as an epidemic.

It is possible to differentiate clinically between these two forms with a high degree of accuracy.

I think Colonel Thurston's divisions into acute, subacute and chronic bacillary dysentery are too arbitrary. I have seen many cases of acute dysentery last for three weeks and clear up entirely.

Yours, etc.,

July 27th, 1944. "UNCLE HARRY."

NEW GUY'S HOSPITAL.

To the Editor of the GAZETTE.

SIR,—Recently a meeting was held in the Medical School to consider the Hospital architect's report on the "new Guy's." A few opportunities were then given to members of the meeting to make suggestions or alterations.

To this meeting the staff of the Hospital was invited with the exception of the house officers.

It can be said that these new buildings, of which we have had a glimpse when the models were on view, will take seven, ten or, maybe more years to come about after the War. Surely, among the house officers and students at Guy's and the main hospitals of the Sector some future members of the staff may be found. Would it not then be reasonable that these men, who have got to live and work in these new buildings, should have some opportunity to offer suggestions or at least to hear how the new Hospital is to be arranged.

Yours, etc.,

G. W. GARLAND.

Guy's Hospital, S.E.1.

Life in India

EXTRACT FROM A LETTER FROM FLT.-LIEUT. W. B. D. MAILE.

I HAD a wizard game of squash last night before going out to dinner with the Chinese, What a party it was ! They gave a dinner in the Chinese restaurant in the city as a farewell gesture to Wing-Commander S——, who has been their liaison officer, and about a dozen of us were invited. The essence of Chinese hospitality appears to be to try and make their guests drink as much alcohol as possible in the least possible time ! I've never seen anything like it. We arrived at about 8.30 p.m. and drank solidly for about half-an-hour before sitting down to dinner, which, of course, we had to eat with chopsticks. It's difficult enough when in full possession of all one's faculties, but you try it after a few stiff whiskies ! They have a wretched habit of filling up your glass—incidentally, they never let it remain empy—and then suddenly saying : " *Gambay* ! " This means that you have to empty your glass at one gulp and turn it upside down on the table. If you refuse, it's almost a personal affront. So after a few " *gambays* " it is remarkable what a rosy hue the world takes on ! The meal consisted of shark's fin soup, fried prawns, some kind of chicken, then fish followed by noodles and bamboo shoots, and finally ended with fried bacon and cabbage. The whole time whisky was flowing like water, so that the speeches at the end were rather incoherent. We had a long table down the middle of the restaurant, and, as you can well imagine, as the party got going, the other customers hurriedly left. Anglo-Chinese relations last night were just 100 per cent. ! It was an evening I shall never forget and, nor for that matter, will my digestive tract ! I nursed it most carefully on lime-juice and carbohydrate to-day. The Chinese are a most affable and hospitable race from what I see of them, punctiliously polite to an alarming degree, but very quick to take offence, and one has to be awfully careful what one says. A lot of the fellows here speak excellent English and, when " relaxed," are very good company. Their M.O., who I shepherded along in the ways of R.A.F. procedure as far as the medical department is concerned, has mosr " interesting " and " original " views on treatment, but the patients respond very well. It's really quite extraordinary, when I am doing his medical stores for him, the number of common drugs for which he has no use. . . .

Sport

Cricket

GUY'S *v.* BECKENHAM C.C.

(*Played at Beckenham on August 5th.*)

Result : Guy's won by nine wickets. Score : Beckenham C.C., 161 for six ; Guy's, 179 for one.

On one of the few fine days of the season Guy's again lost the toss and took the field. Underwood, assisted first by Lewis and later by Bentall gave Beckenham a good start, two wickets being down for 121. At this stage the Guy's bowlers gained better control of the ball, and Beckenham declared at tea for 161 for six.

The Guy's batting left little to be desired. Murphy, in making his century, meted out heavy punitive treatment to all types of opposing delivery, his driving and hooking of the short ball, especially eliciting laudatory comment from the critics, who revelled in seeing something well done.

In the earlier stages of the game he was ably assisted by Williams, who compiled his 31 with constant reference to the book, and was unlucky to be run out when the ball glanced off him on to the wicket. Later Sheerboom joined Murphy to bring the game to a brisk and successful conclusion with several characteristically wristy strokes.

Team.—E. G. Murphy, L. D. Carton-Kelly, D. J. Sheerboom, A. E. Trist, R. G. L. Brittain, I. A. Munro, K. G. Ptrichard, J. D. Williams, D. P. Nicholson, P. S. Holmes, W. B. Webb.

Sailing Club

As reported in a previous issue of the *Gazette*, the first two inter-hospital races were not a great success for Guy's. The third was a great improvement, and since then we have had nothing but successes.

June 21st.—Guy's (D. J. Reid and J. Wallace) *v.* King's, Middlesex and Royal Free.

Guy's had a bad start, Middlesex crossing the line well ahead, closely followed by Royal Free. King's did not prove to be an opponent, as they shipped a large sea during a heavy squall soon after the start and had job enough to reach their moorings without sinking! The Royal Free boat by skilled sailing, rounded the mark just inside the Middlesex boat making things look black for Guy's. However, on the return beat skilled sailing enabled Reid to overtake both boats and gradually establish a lead of several hundred yards, to win by 12½ minutes. Royal Free were second, very closely followed by Middlesex.

July 10th.—Guy's (D. J. Murch and D. J. Reid) *v.* King's, Royal Free and U.C.H.

Once again a strong northerly wind was blowing, so much so that Guy's decided to reef. After the start U.C.H. established a good lead, followed by Royal Free and Guy's. This position remained the same until the run home, when once again Guy's overtook all opponents by backwinding each in turn, then sailing through their lee, to win by 2 minutes. U.C.H. were second, followed a minute later by Royal Free.

July 26th.—Guy's (D. J. Reid and G. B. Elphicke) *v.* London, Middlesex and St. Thomas's.

This race was very nearly cancelled, due to enemy action, but with the Union Jack still flying, the boats crossed the line at the precise time laid down in the fixture-list. London and St. Thomas's soon pulled ahead, leaving Guy's and Middlesex to fight it out. By the time Chiswick Eyot was reached, Elphicke had closed the gap between Guy's and St. Thomas's although they were not overtaken. By this time Middlesex were well astern. After rounding the buoy London failed to give way to Guy's (starboard tack), and were later disqualified for this flagrant breach of the rules. Guy's approached the mark on the starboard tack and had to alter course to avoid St. Thomas's, who were just ahead on the port tack. This led to another protest which, unfortunately, could not be settled, as there were no other witnesses. The result was a resail between the two boats. This took place on Wednesday, August 2nd, and resulted in a win for Guy's by nearly 8 minutes.

The race on July 10th marked the middle of the season. By then Guy's was holding fourth place :—

Hospital.	*No. of races.*	*Points.*
Middlesex	5	24
U.C.H.	5	24
St. Thomas's	5	23
Guy's	5	21
Bart.'s	5	20
Royal Free	5	19
King's	5	18
Charing Cross and Royal Dental	5	16
London	5	14
Westminster	4	3

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

July, 1944.

M.R.C.P.

Ft.-Lieut. B. G. C. Ackner, M.B.(Camb.) R.A.F.V.R.
R. Moore, M.B.(Lond.), L.R.C.P.

SOCIETY OF APOTHEACRIES OF LONDON.

FINAL EXAMINATION.

July, 1944.

Surgery.—*K. R. J. Coates, D. T. H. Paine
Pathology, Bacteriology and Forensic Medicine.—K. Lewis.
Midwifery.—M. J. Blunt, D. O'Keefe.

* Has completed the examination.

UNIVERSITY OF CAMBRIDGE.

FINAL M.B. EXAMINATION.

Easter Term, 1944.

PART I.

Surgery. Midwifery and Gynæcology.

S. M. Hilton J. M. Thomas
D. J. Morton

PART II.

Principles and Practice of Physic, Pathology and Pharmacology.

S. M. Hilton J. F. N Sidebotham
R. E. Irvine S. M. Vine
J. Lorber

Awards

Order of King George 1st Silver Cross (Greece).

The above decoration has been awarded to Major G. B. Palmer, now serving with the 2nd New Zealand Expeditionary Forces.

Papers by Guy's Men

D. W. C. Northfield and Another. Intra-Oral Splint for Facial Palsy. *Lancet*, 1944, ii, 172.

Change of Address

H. J. Atkins, Lieut.-Col., R.A.M.C., 103 British Gen. Hsp., C.M.F.

R. M. Corker, Ft.-Lieut., R.A.F., 81302, R.A.F., India.

H. E. Holling, Surg.-Lieut. Cmdr., R.N.V.R. H.M.S. *Lanka*, c/o G.P.O.

H. F. Lunn, Captain, R.A.M.C., 103 British Gen. Hsp., C.M.F.

C. H. Marshall, Lieut.-Col., A.D.M.S., c/o A.P.O., E. Africa Command.

P. L. Masters, Lieut., R.A.M.C., 309196, c/o Lloyds Bank, Bombay.

Births

SIRETT.—On August 4th, to Vanora (née Gellibrand), wife of Thomas Sirêtt, of 95, Wellington Hill West, Bristol—a daughter.

Marriages

BROUGHTON—CLARKE.—On July 27th, at Sutton, Surrey, David Hugh Broughton, Surg.-Lt., R.N.V.R., to Barbara Estelle Clarke, C.S.P.

WRIGHT—MACKENZIE.—On July 20th, 1944, at East Church, Inverness, Lieutenant Lionel P. J. Wright, R.A.M.C., to Catherine Elizabeth Ferguson (Eline) Mackenzie, S.R.N.

EDS {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

ALTHOUGH Sir Arthur Hurst was hardly known to the present generation of students his death has been deeply felt throughout the Hospital. It seems as if there has gone from us a man who remained a "student" till the end of his days, and, indeed, there was no man more worthy of the title, for he was never satisfied even with his own vast knowledge of medicine, being the possessor of boundless energy and enthusiasm for all sorts of original work. If the inspiration of one's fellow-workers be considered a mark of true greatness, then Sir Arthur was truly a great man.

The author of his obituary in the *British Medical Journal* writes that "Guy's was to remain his great love." And so it was even up till his death. We do not know the half of what he has done for the Hospital, but we do know of, and fully appreciate, his return to the Hospital after his retirement in 1939 to help with the ward teaching. His services to the Hospital were acknowledged by his election to the Governing Body in 1942 and his interest therein never flagged. Indeed, only a short time before his death he was present at a meeting of the Governors on the occasion of Lord Nuffield's gift to the Hospital. Few of us realised under what physical handicaps he suffered, but when we knew our gratitude went even deeper.

To us as students he was a great and inspiring teacher, giving so much more to the life of the Hospital than he could possibly have received from it. We shall be proud to say, in the years to come, that we were pupils of Sir Arthur Hurst.

THE Students' Union has been active recently in sounding public opinion with regard to teaching and the enforced lack of clinical material. We print in this issue a letter from the Chairman of the Students' Union Committee, summarising the results which were obtained at a meeting held recently to discuss this matter.

The Students' Union has had rather a chequered career since its inception, and the election of student representatives has been rather neglected. In the near future the Union will be a very valuable and useful means of conveying student opinion to the authorities, and we would suggest that the election of representatives be put on a sound footing now and that new students be made aware both of its existence and that they owe it a certain measure of support.

Furthermore, it has been suggested that the *Gazette* should come under the control of the Union. This we strongly oppose—quite apart from administrative and financial reasons. The *Gazette* is produced, not only for students, but also for nurses, members of the staff, Guy's men and women at home and abroad, not to mention other hospitals and libraries. Incidentally, student subscriptions amount to considerably less than these others.

Setting aside the question of the tradition that it has always been an independent organ, we feel that the columns of the *Gazette* should be open to anyone connected with the Hospital and with the medical world.

WE should like to acknowledge with thanks the letters we receive from time to time from old Guy's men and women abroad. It is good to think that the *Gazette* acts as a sort of link, so please continue to write and send us news of mutual friends, past and present.

DR. IDRIS JONES, of St. Mary's, is very kindly helping us with our teaching problems by giving a weekly medical round for senior students.

DR. D. R. S. SAUNDERS has left the post of Editor after nearly a year's successful office. We welcome the assistance of Mr. J. D. L. Reinhold to the Editorial Staff.

Obituary

SIR ARTHUR HURST, D.M., F.R.C.P.

GUY'S mourns the loss of one of her most brilliant sons and all of us who knew Sir Arthur Hurst grieve the loss of a constant and charming friend.

Hurst, a demy of Magdalen, came to Guy's in 1901 and soon showed himself outstanding among his contemporaries, for he carried all before him, winning the Treasurer's gold medal in both Medicine and Surgery. At the early age of twenty-seven he was elected to the staff, and even before this he had initiated original investigations and continued to develop many lines of research which soon won him an international reputation. His fertile brain was constantly engaged on new problems and their solution, illuminating many aspects of medicine. Hurst's knowledge of medical literature was encyclopædic, his advice being widely sought and never in vain.

Among the many subjects in which Hurst interested himself was the study of functional nervous diseases, and about this he held very definite views. During the last war he commanded the Seale Hayne Hospital for these diseases and he collected a small band of followers. There he cured large numbers of cases of functional paralyses, performing what seemed to the men and their friends miracles. The cinematograph films he took of the cases before and after treatment were dramatic and served as evidence of the success of his methods.

But it is not only as the penetrating physician that Hurst will be remembered, for he enhanced the traditional reputation of his Hospital by his bedside teaching and his well-known ward rounds became famous, a Mecca for many physicians from all over this country and visitors from others. He had the wonderful capacity for creating enthusiasm in all with whom he came in contact, his students, house physicians and registrars being stimulated to carry out their own investigations and the Hospital Reports which he edited for many years gave ample evidence of the results of that enthusiasm.

Hurst was a lifelong sufferer from asthma, often very severe, and his heroism in refusing to allow it to interfere with his work was remarkable. He decided, therefore, to live out of London and for several years before his retirement from the staff he lived at Ascot, near his clinic in Windsor Forest. Soon after the outbreak of war he gladly accepted the invitation to return to Oxford to help with medical teaching and his five years there were among the happiest of his life.

He wrote with facility and published many articles and, while at Oxford, rewrote his book on the medical diseases of the War. Not content with all these activities he offered to resume teaching at Guy's, an offer which was at once accepted. His manifold services to Guy's led to his election as a Governor of the Hospital in 1942.

Sir Arthur, as he became in 1927, had a vivid personality with a keen sense of humour though to some he must have seemed serious and even austere till this impression was dispelled by his irradiating smile. Both at Ascot and Oxford his house was always open to his wide circle of friends. In addition, he was most versatile and could turn his hand to many things. In his earlier days he painted several admirable pictures and, later, turned to modelling. Many will call to mind his excellent head of a senior colleague and another of one of his children.

For many years he went to Switzerland, both to gain relief from his asthma and to enjoy the winter sports, but in the end his asthma took its toll.

Finally, it would be impossible in a few words to do justice to Hurst's brilliant life and charming personality. Our deepest sympathy goes to his wife and children in their sudden bereavement.

W. M. M.

A memorial service for the late Sir Arthur Hurst was held in the Hospital Chapel on Tuesday, August 22nd. The Rev. V. T. McLaughry conducted the service and Mr. W. M. Mollison gave a short address. A similar memorial service, at which Professor Ryle spoke to Sir Arthur's memory, was held in the Radcliffe Chapel, Oxford, on the same day.

Photo by Vandyke

SIR ARTHUR HURST, D.M., F.R.C.P.

The So-called Typical Adenoid Facies

By T. B. LAYTON, D.S.O., M.S., F.R.C.S., *Surgeon i/c Throat and Ear Department, Guy's Hospital.*

A Lecture delivered to the Medical School on Monday, July 17th, 1944.

I AM going to talk to you to-day about an extraordinary example of herd psychology. The whole of the medical profession in this country was mesmerised by two men of striking personality into believing in a relationship of cause and effect between nasal obstruction and a certain configuration of the face and palate, and because it was believed that the commonest cause of that nasal obstruction was adenoids the term " typical adenoid facies " was given to it.

The idea was never taken up in France, and was not originally taken up in the United States. It was entirely special to this country.

Supposing we have—(*a*) adenoids causing nasal obstruction and (*b*) a particular configuration of the face, there may be four possibilities with regard to cause and effect: (1) they both may be the result of some third factor and bear one to another no causal relationship whatever, (2) the adenoids may be due to the configuration of the face, (3) the configuration of the face may be due to adenoids, or (4) they may be absolutely independent one of another.

There is some reason for believing that both the adenoids and the configuration of the face used to occur in the same person. There is no evidence whatever that the adenoids were due to the configuration of the face, which was the idea taken up by a certain number of people in France. There is no evidence whatever that the configuration of the face is due to nasal obstruction. But two persons of striking personality so " got it across " the medical profession in this country that the onus of proof came to rest with those who did not believe it instead of their being entitled to demand that those who did believe it should produce the evidence for their faith.

I thought that the whole matter was dead and that we should never have to go into it again, but the other day there appeared a letter in the *British Medical Journal* by Mr. R. A. Worthington, of Exeter—a man of about my own seniority—who still believes it and quotes as quite definite evidence something which one of those two vital personalities suggested might possibly be evidence in favour of it. You will note how the evidence which is suggested as possibly supporting a hypothesis by a man writing in 1906 is accepted nearly forty years later as convincing evidence in favour of the hypothesis being a fact.

I attended Lane's lectures on anatomy in October, 1901. Lane was a wizard; nothing could control him, nothing compelled him to do anything according to the dull routine, and when he lectured on anatomy he gave you all sorts of ideas ; he told you a lot of unorthodox stuff—excellent, if you used it properly, as material for thought, though quite valueless for getting through an examination and not of much use for learning anatomy. He would come into the theatre and say : " We will to-day study the mechanics of the face." He then took a bit of chalk with his delicate hands, broke it into two and, turning his back to the audience, waved both hands about all over the blackboard until you wondered whether he was trying to produce a diagram of Hampton Court maze. Then he would turn and would line in various parts of the shaded chalk marks which he had put all over the blackboard, and there was the most perfect cross-section of the face that you could possibly find in any anatomical diagrams, with the orbits, the sinuses, the jaws, and the teeth all in place. After this he would point out how osseous tissue, though the hardest of all the tissues in the body, was the one which in its growth and development was most easily modified by any long-continued mild force exerting pressure upon it. He would then explain how, if the individual could not breathe through the nose, he breathed through the mouth. He made the whole lot of us inspire through our mouths, and he drew our attention to the fact that in doing so we felt the cold current of air constantly impinging upon the palate and this was what distorted the whole of the bones of the face. Following this he would take another little piece of chalk and with rapid strokes would change his diagram. Up went the arch of the palate, in went the malar bones, squash went the maxillary sinuses, forward came the hard palate. He would then explain that although there was a superior protrusion the total amount of room on that alveolar margin was less than in the person with the broad palate and, therefore, there were the irregularities, up came the central incisors.

I do not know whether Angle had then described his classification of the forms of the teeth, but if any of you use that classification to-day the one concerned is Type 1, in which a determining factor is narrowness between the first pre-molars. That is a thing which is measured with a fair degree of certainty.

The whole of the evidence with regard to that so-called typical adenoid facies was the cold current of air that all we youngsters—mere boys from school—felt pressing up against our hard palates as we inspired heavily through the mouth.

At the London Hospital there was another of these vital personalities—namely, the throat surgeon, Mr. Lambert Lack. I never knew him, though I heard him on a few occasions, but both his contemporaries and his juniors were mesmerised by him as we at Guy's were mesmerised by Lane. When I was honorary secretary of the Section of Laryngology of the Royal Society of Medicine my old president, Mr. Charles Parker, said that of all the men of his time Lambert Lack was streets ahead. The men of my time, if they were at the London Hospital, worshipped him in exactly the same way as the men at Guy's worshipped Lane, though I am not sure that with their worship there was the blend of criticism which Lane himself taught us to apply to the teaching of everyone, so that I early began to doubt the accuracy of his hypothesis.

I want you to remember this, however, that Lane did not deduce from his hypothesis on the adenoid facies that operative surgery was necessary. He maintained that if you reconstituted the breathing the pressure of air through the floor of the nose would stay the process of the typical adenoid facies even if it did not restore the anatomical configuration of the palate. He was the original advocate of breathing exercises which have to-day become a part of the instruction in every physical training school in the land and a part of every scheme of rehabilitation which is now extending into later life.

When I first came into the throat department at Guy's we gave out a form, some of which I am able to produce to you, to a very large number of parents in order to get them to make their children undertake these breathing exercises. While I was away during the last war there got printed on to the back of these forms instructions to the parents with regard to the care of the child for the first forty-eight hours after the operation of tonsils and adenoids had been performed on them. As another interesting example of herd psychology, once that was printed on the back of these forms I was never able to get any clinical assistant, house surgeon or dresser to use this paper for the original purpose for which it was devised—namely, to reconstitute nasal breathing and so save the need for an operation. We are at last going to get these forms reprinted. When I asked that they should be reprinted if there were no copies in existence, the nurse went and asked the clerk in the superintendent's office for some and the clerk said, "Do you often use them?" To which the nurse replied: "No, hardly ever." Whereupon the clerk said: "Oh, then, I don't think we need to get them reprinted." They are not used because they are not there; they are not there because they are not used and it is thought they are not needed, and so we go round and round.

It is to the credit of the dental profession that it was they who took the matter up scientifically. They doubted the statements which had been pushed out to them by members of the medical profession, particularly surgeons and rhinologists, as though those statements were gospel for the dental surgeon to learn and adopt. Having doubted, they determined to put it to the test. In the year 1912 the British Society for the Study of Orthodontics decided to appoint an investigation committee to study the whole problem of dental deformities, and they further decided to have a rhinologist upon that committee. Owing to the fact that my old friend Mr. Montagu Hopson was a member of the committee and that I had just been put on the staff of Guy's Hospital, I was made that rhinologist member. I never shall forget the first meeting of that committee of six dental surgeons and myself. We were going to study the whole question of dental deformities and, amongst other things, came the question of infantile thumb-sucking. There was silence throughout the room. I was sitting at the bottom of the table and I looked up and burst into laughter, for there were the whole of these serious-minded gentlemen all sitting round the table sucking their thumbs and thinking what influence such a fault would have upon the palate if they were still infants or small children. The burst of laughter became general, and the committee then settled down to really scientific discussion. They decided first of all that the whole subject of abnormalities of the jaws was far too big a problem to tackle straight away. I would ask you to remember that point. Whenever the question of "investigating the whole problem of . . . ." supposing it is science, or of "dealing with

the whole problem of . . . ." supposing it is a question of administration, is brought forward, it never seems to come to anything. But if you investigate or deal with a small portion of the whole you take it a little bit further. At the end of a year you do not seem to have done much, but at the end of eighteen months you may have done quite a lot, and that was what happened in this instance.

We decided that the subject on which we would start should be the typical adenoid facies, particularly in its relationship to the deformity of the palate as dependent upon adenoids.

That brought us to the question, " What is adenoids ? " One of the wise sayings of Lord Horder is, " In medicine the use of terms is vital." I find that if you want to stump a junior you have only to ask him what he means by some term that is batted about like a shuttlecock between the battledores of the tongues of people at the Royal Society of Medicine and in places where they talk. On the other hand, if you ask that question of a contemporary or a senior you are looked upon either as being flippant or as lacking in intelligence. I still maintain, however, that every single person who uses the term " adenoids " has to be prepared to explain what he means by it.

By adenoids I mean a permanent enlargement of the lymphoid tissue of the naso-pharynx sufficient to obstruct either the posterior nares or the eustachian tube or both. I would have you note the two words " permanent " and " sufficient." A transient swelling of that lymphoid tissue as a result of recent infection is not adenoids. However much lymphoid tissue there is in the naso-pharynx, it is not adenoids unless it obstructs either the posterior nares or the Eustachian tube or both.

What, then, are the typical signs ? You can determine the presence of adenoids either by the post-nasal mirror or the examination of the drumhead. By other means you can determine that adenoids are not present but not that they are present. During the time when I was clinical assistant to Mr. Steward the post-nasal mirror was of much greater value than it is to-day because we were then dealing with children older than those who are now brought into the throat clinic as cases of adenoids. Mr. Steward's teaching was quite definite and good. If you look at the back end of the septum with the post-nasal mirror you will see it going up quite straight as in Fig. 1. There are no deviations in the posterior end of the septum. Then it branches out on either side like the arches of a Gothic cathedral. On the other hand, if adenoids are present we get a different appearance, that of a T-shaped junction as in Fig. 2, more like Stonehenge.

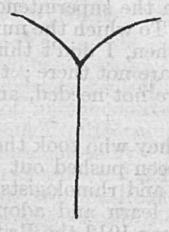

FIG. 1.

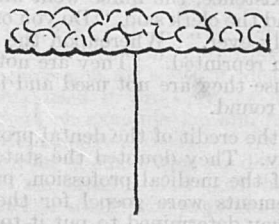

FIG. 2.

If this junction occurs sufficiently low down it obstructs breathing through the nose and the condition may be called adenoids.

When you look at the drumheads you find a characteristic appearance. The drumhead shows three things :—(1) a diminution of the posterior angle suggesting retraction ; (2) a blurring and distortion of the cone of light, in my opinion confirming that retraction, and (3) a rose pink appearance seen through the drumhead at its bottom part behind the blurring. That rose pink is quite distinct in colour and position from the two other discolourations of the drumhead—namely, that which is seen through the drumhead in otosclerosis, the flamingo pink appearance, and the dusky red, containing some blue, which involves the superior portions of the drumhead and the contiguous part of the meatal wall which is characteristic of the early stages of acute otitis media.

Having decided what adenoids were, the question was whether they could have any effect upon the development of the palate. To do this the pressure must be

exerted over a considerable period of time. We decided that we would study the subject only in children over the age of six, by which time the first permanent molar would have developed. Then came the question as to how we should arrive at the knowledge as to whether the child had been breathing through the mouth over that period of time. It was decided that I should always obtain the history before I examined the patient in order that I should not be prejudiced in favour of getting a history of mouth-breathing in a child in whom there was a high-arched palate. There was also the problem of the suggestibility of the mother, and it was decided that I must always get my history by indirect questioning and that if I had to ask the mother straight out: "Does the child breathe through his mouth or does the child sleep with his mouth open?" I must throw that case on one side and not use it for the purpose of this investigation.

I believe that those are sound scientific rules for interrogation when laying down a statistical survey. We were all so confident that this high-arched palate was common and that adenoids were very common that it was thought that I should quickly get a hundred or more cases from my Out-patients' department at Guy's and my school clinic at St. George's Dispensary, where I was then working. At the end of fifteen months, so far from having got more than one hundred cases, I had managed to get only thirty-six. Having got my patients I got one of the senior dental students or the dental house surgeon to come along and make casts of them. These casts I took to the committee. The first thing I did before anybody looked at the casts was to read out my evidence with regard to the persistence of mouth-breathing over a period of at least six months, and out of that thirty-six the committee rejected twelve, leaving us with twenty-four. That was a very embarrassing thing for me. It was also rather a blow, because I had worked pretty hard at it. There were, it is true, some days when I was so busy that I forgot all about it, but after a year's work to get only twenty-four cases looked as if I had been very lazy and unobservant.

The next thing to be done was for the dental surgeons to determine whether there was any contraction of the arch. Then I began to smile again because I was intensely nterested on the great difference of opinion that arose among dental surgeons as to whether there were contracted arches or not. Finally we hit upon that typically English principle of compromise and divided the cases into:—(1) undoubted contraction, (2) certainly no contraction, and (3) some evidence of some contraction. In this last class half the dental surgeons said that there was definitely no contraction and half said that there was in each case. We then correlated the findings of the dental surgeons with my story. There was just as much evidence of mouth-breathing in the cases which had no deformity as in those which had undoubted deformity of the palate and in the cases which were in the intermediate stage. We brought that evidence before the meeting of the British Society for the Study of Orthodontics in March. We apologised for not having a large enough number of cases. We agreed that it was not large enough to justify any conclusions, and after a preliminary discussion we adjourned it for the summer, intending to take it up again in the following winter session. The year was 1914, however, and by the next October most of us were otherwise engaged, and that work has never been taken up again by that society. But in the views that we placed before the Society we made one mistake—namely, the necessity for getting large numbers of cases for the statistical proof. If I was unable in the course of sixteen months to get more than thirty-six cases of children breathing through their mouths over a period of six months, and out of that thirty-six the Committee turned down one-third on the ground of insufficient evidence, had we not a right to deduce that the enormous number of children breathing through their mouths and needing operations for their adenoids do not in fact exist, and had we not got quite good negative evidence with regard to the dependence of the high-arched palate and the typical adenoid facies upon nasal obstruction?

There the matter lasted until after the war, when Sir Arthur Keith took it up. He had one great difficulty—namely, to persuade any of his brother anatomists that this deformity existed at all. He went through all the skulls in the Royal College of Surgeons museum which came from these islands, and he found that where this deformity occurred it was not discoverable until the beginning of the eighteenth century, the time when country life was beginning to give way to town life and town conditions. You have only to look at the early maps of London to realise that up to the seventeen hundreds London itself was only a village, and that everyone could easily get into the fields and that fresh food was easily obtained. The problem of disease in those days consisted in dealing with alimentary infections, the result of the inadequate disposal

of excreta and with rat-borne plague, not with air-borne infection and with vitamin deficiencies. Sir Arthur Keith never published his results, but I do not think that I am misinterpreting his views when I say that he thought there was some evidence that adenoids and the high-arched palate tended to occur in the same person, but that there was no evidence that either was dependent on the other. They were both secondary to some constituent in town life.

The next thing that happened was that adenoids disappeared. Gentlemen, to-day, adenoids, as defined by me and as known to those of us who were in the Throat Department here in 1909, do not occur. It is perfectly true that my younger colleagues have put the name to some other condition in the naso-pharynx which they call adenoids, and they accuse me of being unscientific because I insist upon retaining the term for the condition for which it was originally invented. But they have never described the condition that they to-day call adenoids, and I am very suspicious of any lesion that is found at the edge of a surgeon's knife by continuing to carry through the performance of an operation that no longer is necessary in surgery.

If you carefully go into these questions in children you do not find large masses of lymphoid tissue permanently obstructing the posterior nares or the Eustachian tube or both. You put your finger up the back of the nose and feel, not for the amount of lymphoid tissue, but for the space in front and below at the back of the choanæ. If you learn to make the anterior rhinoscopy carefully in a large number of cases you can see from the anterior nares the soft palate come up on phonation or on swallowing. If you see the soft palate come up like that there is not sufficient lymphoid tissue in the nasopharynx to obstruct breathing and to be called adenoids. It is worthy of note that although adenoids have disappeared the structure from which they arose remains, for there is a certain school which believes that sub-mucous lymphoid tissue of the upper respiratory tract is some evil propensity on the part of the human being, like original sin. Therefore, when they remove the tonsils they remove also what they call the lingual prolongation of the tonsil, and then, being very dextrous with their fingers, they take away most of the lingual tonsil itself, while they perform what they describe as a thoroughly efficient removal of the adenoids and leave none of the sub-mucous tissue of the upper respiratory tract. If they come across a patient in whom they can find a tiny little bit left behind they tackle it and call it the removal of adenoid-remnants, and suggest, by their manner, if not in so many words, that the man who had left that behind was guilty of malpraxis or of bad surgery. Really it was not the misdoing of the surgeon at all; it was old Dame Nature carrying out her principle that lymphoid tissue is required in the upper respiratory tract of the young.

Then Mr. Somerville Hastings came along, stimulated by the dental surgeon, Mr. Warwick James, and found that the vast majority of these children were not breathing through their mouth at all—that they were merely catching flies with their mouths open! Presumably they had their tongues, not in their cheeks, but up against their soft palate. A new term, "posterior oral aperture," had to be invented in order to indicate the fact that although the patient had his mouth open, air might not be passing across the faucial region.

I do not think you have any right to-day to determine that any child has nasal obstruction unless you have used Mr. Somerville Hastings's test of putting a bit of cotton-wool in front of each nostril and of the mouth to find out which of these openings he is, in fact, breathing through.

Last stage of all. A young rhinologist has recently made an important observation —namely, that the majority of children go through a period of breathing through their mouths while they are asleep; this belongs to a certain stage of their development; they grow out of it and it does them no harm whatever.

Finally, the typical adenoid facies has practically disappeared. I have had a good example of it in my out-patient department to-day in a girl who was operated on for otitic meningitis a fortnight ago. But it is so rare that it takes a long time to find a case to demonstrate to students. Lastly, a positive bit of negative evidence: there are a certain number of people—very few—who have a congenital obstruction of the posterior nares. I doubt whether any rhinologist sees more than two or three in the course of his career. The anatomists know nothing about it. So far as I know, there is no skull anywhere extant showing such a deformity. But from among these people nobody has as yet produced a cast of the mouth which gives any suspicion or suggestion of this peculiar deformity. Surely, gentlemen, that is an example of what may be called—I cannot think of the phrase, and it is two o'clock and time to stop!

Correspondence

CLINICAL EDUCATION.

To the Editor of the GAZETTE.

SIR,—It has become increasingly obvious during recent weeks that the restrictions which have of necessity been placed on the admission of cases to Guy's and elsewhere are imposing considerable handicaps on clinical teaching. Indeed, so acute did the shortage become that it was rumoured that teaching was to be suspended until conditions improved, it being accepted that the crisis would be only a temporary one. I can confidently state that no such step is contemplated. However, it is possible that things may not improve for a few months, and it would be wise to consider what might be done to make the best of a difficult situation. Hopes are held out that a number of beds at Guy's and Farnborough will be freed for the admission of teaching cases. Subject to such cases being available, this would improve matters but hardly restore them to normal.

The other suggestion is that arrangements be made for students to attend other hospitals where there are plenty of cases to see. A colleague confidently tells me that such hospitals are to be found within easy reach of London, but the general impression is that such a step would involve journeying farther afield. At last week's meeting, attended by some eighty students, it was not possible to give more than a broad outline of such a scheme. However, it was decided that sufficient students were willing to avail themselves of any arrangements that might be made to justify putting the proposition to the Medical School authorities as a suggestion from students. It is hoped that further information will be available soon.

On the other hand, a considerable body of opinion was in favour of waiting and seeing. This view was based on either the hope that our armies would solve the problem for us in a few weeks or on the fear that students sent to other hospitals might find themselves worse off than before—"we know what we are, but we know not what we may be."

May I add one further point of my own? Quite apart from the present situation, I think that time spent by students in the medical schools and wards of other hospitals would be most profitable. An attitude of loyalty to the views and traditions of one's own hospital is commendable, but to carry it so far as to heed but little the teachings of others is a course of impious stubbornness. Could we not resolve our present difficulties in such a way that this tendency be avoided both now and in the future?

Yours, etc.,

IAN A. H. MUNRO,

Chairman of the Student's Union Committee.

County Hospital,
Pembury, Kent.

To the Editor of the GAZETTE.

SIR,—In your obituary of the late Mrs. Fagge you referred to the lady pupils as educated ladies, inferring thereby that the other members of the nursing staff were neither educated nor ladies. That is quite wrong. The great majority of the nurses were both educated and ladies; in fact, the proportion of medical students who were both educated and gentlemen was about the same.

Even at that time it was felt that the "L.P." class was a snobbish anachronism though several years passed before it was abolished.

If you will pardon an abrupt change of subject, I should like you to accept my congratulations on the way in which you are keeping the *Gazette* running. Every number has something of interest and value; as an old editor, I appreciate what that entails.

Yours, etc.,

"OLD TIMER."

Hospital Information, etc.

Pass List

UNIVERSITY OF LONDON.

M.D.

July, 1944.

Branch I.—Medicine.

P. Forgacs

Branch III.—Psychological Medicine.

W. E. W. Bridger

SECOND EXAMINATION FOR MEDICAL DEGREES.

July, 1944.

G. C. Ambrose	R. L. Luffingham
J. H. Apted	A. G. McCallum
J. H. Baylis	B. C. Morgan
G. L. Blewett	J. B. Morrison
J. F. de la Fresnaye	T. E. Oppe
J. B. Eades	J. A. R. Parker
R. L. Edwards	H. H. B. Perkins
J. G. Hamilton	J. Southgate
A. J. Heber	P. J. F. Walsh
C. A. Higgins	J. L. Warren
K. E. Hodge	R. D. Willcock
A. J. I. Kelynack	P. Wilson
K. B. Kenyon	

SECOND EXAMINATION IN DENTAL SURGERY.

PART I.

July, 1944.

B. M. Bilton	A. K. Parsonage
R. A. Dean	A. Rooms
J. G. L. Knowles	J. S. Rose
S. F. Lamb	P. G. Shingler
R. A. Morsman	

The following Students are credited with Anatomy and Physiology :—

J. L. Attenborough	A. H. R. Rowe
A. Levy	P. H. Smith
R. A. J. Mayhew	W. J. Tulley
L. A. Rosen	

PART II.

C. D. Baker	*J. B. Kirkwood
*S. J. Bell	B. H. de C. Prideaux
R. A. C. Dove	R. Rapaport
G. B. Elphicke	J. C. Schofield

* Awarded a mark of distinction.

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.

July, 1944.

Honours.

H. S. M. Crabb

Distinguished in Surgery.

Pass.

J. B. Andrew	B. N. Joyce
J. A. Ireland	A. D. Robinson

Supplementary Pass List.

The following Students have passed in Group II :—

D. H. Norman	S. C. J. Pink

FIRST EXAMINATION FOR MEDICAL DEGREES.

July, 1944.

(Internal Students.)

W. I. Abell	G. L. Jones
B. L. Bisley	J. H. Keeling
J. H. McL. Buckley	E. J. McGuire
B. G. B. Christie]	A. H. Phillips
I. B. Davies	A. R. Phillips
H. E. Dyer	G. F. M. Pierce
M. C. Gilbert	T. C. J. Price
G. A. L. G. Glazebrook	P. T. C. Rowan
A. V. Gledhill	L. Tenebaum
R. W. Glenn	A. H. Walker
R. Handy	T. K. Walker
M. C. H. Jackson	C. B. H. Watson
L. Jacobs	J. G. Whitelegg
I. G. Johnston	

The following Students have completed the External Examination :—

P. Chadwick	R. T. F. Larsen
P. R. Dove	A. H. Mendoza
P. W. Head	C. J. G. Menzies
T. E. Jeffreys	C. S. Ward

The following Higher School Candidate has completed exemption from the First Medical :

D. M. Lewis

(External Students.)

July, 1944.

D. L. Blundstone	A. P. T. van Hamel
A. E. Richardson	

The following Student has qualified for permission to proceed to the Second Medical as an Advanced Student :—

T. M. Owen

Change of Address

M. A. Filose, Lieut., R.A.M.C., 225 P.O.W. Camp, B.L.A.

C. E. Gallagher, Lieut.-Col., R.A.M.C., 21 Army Group, B.L.A.

D. L. Goodridge, Surg.-Lieut.-Cmdr. (D), R.N., H.Q. S.E.A.C.

J. H. Mayer, Major, R.A.M.C., 107 S.A. General Hosp. (V.), C.M.F.

Births

SICHEL.—On August 22nd, 1944, at Sandford House, Bournemouth, to Betty (née Lawson), wife of Captain G. R. McK. Sichel, R.A.M.C.—the gift of a daughter (Barbara Ann).

CORFE.—On June 21st, 1944, to Joyce (née *Figgins*), *wife of Felix N. Corfe, of 196*, Muswell Hill Road, London, N.10—a third son.

FRANKL.—On July 29th, 1944, at Cambridge, to Carmen Wilson (née Hough), wife of Ernest Frankl—a son (Guy Richard Hough).

Marriages

PUNT—MOORE.—On August 12th, 1944, at Methodist Chapel, Brightlingsea, Norman Arthur Punt, M.R.C.S., L.R.C.P., son of the late Alfred A. Punt and Mrs. A. R. Punt, of Wandsworth Common, to Gwendoline Phyllis, younger daughter of Major and Mrs. Frank Moore.

Deaths

BOWLING.—On August 19th, 1944, John Douglas Bowling, L.D.S., R.C.S., aged fifty-six, of 647, London Road, Westcliff-on-Sea.

FAWCETT.—On August 21st, 1944, in London, May Fleming, widow of Dr. John Fawcett.

HURST.—On August 17th, 1944, Sir Arthur Frederick Hurst, D.M., F.R.C.P., of Red Gables, Headington, Oxford, aged sixty-five years.

MITCHELL.—On August 19th, 1944, suddenly, as the result of an accident, Douglas Ashley Mitchell, F.R.C.S.(Edin.), M.D., of Crossland, Bath.

PANTIN.—On August 18th, 1944, Charles Satchell Pantin, O.B.E., M.D., F.R.C.S., *of Finch House, Douglas, Isle of Man.*

TUDGE.—On August 17th, 1944, at his home, Hazeldene, Chipstead, Surrey, Cecil Carrington Tudge, M.B., aged fifty-nine.

EDS. {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

EARLY in the year 1721 is to be found the first mention of Thomas Guy's new hospital. The minutes of St. Thomas' Hospital show that Guy planned to build his new hospital on "parcels of ground" opposite that ancient foundation. "Our worthy governor and benefactor, Thomas Guy, intending to found and erect an Hospital for Incurables, in the close of this Hospital, in the parish of St. Thomas, we have agreed to grant him a lease, or to such persons as he may appoint, of several parcels of ground within the close of this Hospital, and in the parish, upon several leases, and under several ground rents, amounting to £17 14*s.* per annum—purchased by the said Thomas Guy, or in trust for him for 1000 years at £30 per annum, tax free."

A lease for a thousand years! What impudence! And yet what faith in posterity and belief in the value of his charity Guy must have had to make his benefactions on such a grand and imposing scale.

But scarce a quarter of that span of time has run and part of the land which once was so prudently bought lies waste, the buildings on it razed to the ground, hollow mockeries of his humanity and foresight. Perhaps even more cruelly tragic is the scorched rubble whereon stood part of the old St. Thomas' and the broken walls of the present day hospital by the river at Westminster. Truly, poor old Guy's interests have taken some hard knocks. But the temples of healing can never be utterly destroyed by the onslaughts of the barbarians.

Guy was nothing if not an optimist when he looked ahead for a thousand years, and we who seek to build afresh the broken remnants of his idea must catch something of the spirit of his sublime optimism and faith in the generations to follow after.

But our pleas can go unheeded, for the spirit has indeed been caught, as the plans of the broad architectural principles upon which the new Hospital will be based, clearly show.

Making due allowance for the false impressions that plans and models inevitably give rise to, we can readily see, in broad outline, the noble and spacious lines upon which the Hospital is planned, enlarged to a thousand beds, one for each of Guy's millennial years.

If Mr. Lane, the architect of the original buildings, could but see these buildings which will rise upon land that was once the burying-ground of St. Thomas', he might well sigh sympathetically for Mr. Hall, the present architect, with this immense undertaking before him. Lane saw his plans bear fruit in nearly three years, but the sanguine hopes of our student correspondent at Pembury, who writes to us "as one of those many in whose time the rebuilding planned at Guy's will be completed," will scarcely be realised even though work will start as soon as conditions permit, thanks largely to Lord Nuffield's munificence.

To conclude this idle reverie, it might be interesting to wonder if man's wisdom will have caught up with his knowledge sufficiently for one stone of the new Guy's to be left upon another 750 years hence.

THE holiday spirit seems to have caught most of the Hospital just recently if we are to judge by the bronzed features and peeling noses of our friends. We are glad to see Dr. R. I. Macallum back at Guy's again whilst Dr. Thomas is on holiday. Major-General Ogilvie paid us a welcome visit last week for a lecture, and will give a ward round this week. Finally, we wish a speedy recovery to Dr. Ryffel and trust that his femur will unite "medico-eagerly"!

WILL the honorary secretaries or acting honorary secretaries of the various athletic clubs or of any club which is a constituent member of the Clubs' Union, please forward their names immediately to the Medical School Office, indicating which clubs they represent?

In Memoriam

ARTHUR HURST.

An Address given in the Chapel of the Radcliffe Infirmary, Oxford,, August 22nd, 1944.

WHILE thinking, as so many have been thinking during the past few days, of our good friend and very great teacher—Arthur Hurst—now gone from us, I have pondered how best we may balance our immediate and profound sense of loss with thoughts and emotions of another kind. That we should seek such a balance would, I believe, have appealed to him; it would certainly be in accord with the way of life of one who ever balanced physical disability with personal and intellectual achievement and present suffering with hopefulness on his own behalf or transmitted to others. Through an active working life of nearly fifty years, which was constantly interrupted by the storms of illness, it somehow seemed that he "never doubted clouds would break."

The sense of loss, we know, is most grievous in his own home whereto, although in these first days they can comfort but little, our warmest sympathies are directed. Very heavy, too, is the sense of loss among his friends, his colleagues and his students, old and young, in many lands. Of no teacher can it be more truly said that those of us who were his students in youth have remained his students through all the after years. At the quality of the loss which many thousands of patients will feel, patients who have been helped by his skill and knowledge either to health or a better understanding and acceptance of incomplete health, we can only guess.

I would suggest that the best counter-balance to this sense of loss should be our gratitude for many things which have befallen and for many things due to him; a gratitude with many facets and unlikely to be dimmed by the years. On this, perhaps, you will allow me to dwell for a while.

Firstly—with the living, eager Arthur Hurst in our minds, as we so lately knew him—we can be grateful, for his own sake, for the way in which he died. He was enjoying a well-earned holiday; he had spent the day in the country with his family and went on without them to stay a night or two in the home of a close friend, a physician whose skill would have been instantly available had it been needed and had help been possible; and there in an armchair, and not after a wearisome bed-ridden illness, death came to him swiftly and kindly. In his sixty-fifth year he was still at the height of his teaching activity—teaching in Oxford, teaching at Guy's and attracting large numbers of students and graduates to his clinical demonstrations. His busy mind and pen were almost as busy as ever. His well-known "Medical Diseases of War" had been re-written and a new edition has already appeared in April of this year.

Secondly—with his dear partner and children in our minds—we may be grateful that they, who had seen and cared for him in so much sickness, were spared long anxiety and distress and saw him last in a time of holiday relaxation. Perhaps their gratitude for this may in some measure help to temper grief.

Thirdly—we, his students the world over; his colleagues at Guy's or in Oxford or of the units at Seale Hayne or New Lodge Clinic, which were his creation; his associates in the Royal College of Physicians, the Association of Physicians of Great Britain and Ireland and the Pilgrims' Club and many other British and foreign societies—we,too, will cherish a deep gratitude, until our own days are numbered, for wisdom learned of him; for a helping hand at the beginning of a career or in some moment of decision; for his stimulus to the conduct of original work; for collaboration over a paper, in which his was always the master hand; for the provocative quality of his genius; for many keen professional debates; for the privilege of his friendship.

His scientific career began at Oxford. Those who knew him best as a physician should not forget that some of his earliest and best contributions were to physiology. His clinical medicine and research were largely based on physiological methods and prompted by physiological curiosity. And yet his academic interest never allowed him to give second place to the understanding of human minds and frailties into which he often probed with penetrating insight. His scientific career was launched at Oxford,

and here at last his eager mind came home to lend its war-time aid to this young clinical school now growing up in the medical faculty of this ancient university. He loved Oxford and all the associations it gave him with Osler and other great men of his earlier days. A Demy of Magdalen, he also became Radcliffe Travelling Fellow and Prizeman, and later in life received, as one of his most cherished honours, the award of the Osler Memorial Medal.

But if he loved Oxford he loved the School of Guy's no less and all its clinical traditions. Entering the school with a university scholarship he rose to be senior physician to the Hospital and, later, consulting physician and a Governor, and, to everyone's joy, continued to make his famous teaching rounds after he left the active staff. In fact, he may be said never really to have retired from the active service of the Hospital. He was intimate with the story of the great succession of scholar-physicians at Guy's—including Bright, Addison, Gull, Wilks, Fagge, Mahomed, Pavy, and his own teacher Hale-White, who is with us here to-day. And in all this brave succession we may ask ," Was there one with a livelier genius or more passionate industry ? Was there one who touched the advancement of medical learning with a more magic wand ? "

In the Royal College of Physicians he became, in turn, Goulstonian and Croonian Lecturer and, the highest honour of all, Harveian Orator. His output in books and papers was phenomenal; many were translated into foreign tongues. His fame and his professional friendships were both international. As editor of the Guy's Hospital Reports between the wars he converted a famous annual publication into a quarterly journal of high merit, and it was filled year by year with contributions from his own pen or written by his assistants or house-physicians.

What a great mind was his in how frail a body. What purpose and courage filled his nights and days. Some of us who have had the privilege to serve as his physicians in his worst attacks of asthma have found him propped up in great distress of breathing and yet with his bed strewn with books and papers and a new lecture or address in preparation. His spirit was indefatigable and undefeated to the end.

But we should not think of him only as the scholar-physician and the picture would not be complete without a reference to his freer moods and moments. On holiday he could be a delightful companion and full of fun and humour. He had a rich, artistic and literary sense and his sensitive fingers had no small skill in the modelling of clay.

He advanced his subject in many and varied fields of study, including the physiology, symptomatology and radiology of the digestive tract; the nervous diseases, both organic and functional; the anæmias; and his own malady, asthma. Although his increasing deafness compelled him to discard the stethescope he had made a contribution to cardiology, for he and a contemporary during his early years at Guy's wrote the first description of auricular flutter. And always, notwithstanding their academic fascination for him, his researches had the practical objective of improving diagnosis and treatment.

Those of us who have known patients of his are familiar with the regard, and sometimes awe, in which they held him. To some he seemed almost a wizard, but their little science could not tell them on what patient and prolonged and almost inspired studies his seeming wizardry was based.

If stricken by our loss we can, indeed, be very proud. His students always we must pass on a spark here and there from his torch and often direct our own students to his outstanding writings.

To his family here and now we offer once more our loving sympathy and a full assurance of the great honour and affection in which his memory will be held—not only in England, but beyond those boundaries and barriers which the nations still maintain. These barriers he, in his own sphere—by his writings, by personal correspondence, by travels abroad, by his membership of foreign societies and Vice-presidency of the Anglo-Soviet Medical Society, by hospitality to foreigners at home and by great generosity to refugee colleagues from Europe—did as much as one man could to abolish. For these things, too, let us be very grateful and bless him in our thought.

J. A. R.

The Rebuilding of Guy's

THE PRELIMINARY ACTION TAKEN BY THE COURT.

FOR the past two years a Joint Committee of Governors and Staff, appointed by the Court, has been considering the problems that will arise immediately on the cessation of the war in Europe. These problems, which affect the policy of the Hospital as regards future developments and include the reconstruction of buildings destroyed or damaged by enemy action, have been complicated and their solution has been rendered more urgent by the publication of the L.C.C. plan for the rebuilding of London, the Goodenough Report and the White Paper on a National Health Service.

It should be stressed that throughout the preliminary period the Court has given every opportunity to the members of the Staff of the Hospital and Medical and Dental Schools to express their views, and their whole-hearted co-operation has proved of the greatest value. It is very regrettable that members of the Staff who are on active service have not been able to take part in these discussions, and there may be a tendency for them to consider that action should have been delayed. The Court, however, was faced by two alternative possibilities—(*a*) to defer any decision until the cessation of the war in Europe, or (*b*) to proceed with the help of those members of the Staff who were available in London. To have adopted the first of these alternatives would have reacted very seriously on the interests of the Medical School and might even have been disastrous, for in the plan for London no allowance has been made for any increase in the Guy's site; indeed, the plan proposes an actual curtailment by bringing the south end of Great Maze Pond into line with its northern portion. The Court considered that it was a matter of urgency to ensure that an adequate site should be available for extension of the Hospital and for that purpose a ground plan of the proposed rebuilding scheme was essential. The Court, therefore, was compelled to accept the second alternative as the lesser evil of the two.

The Joint Committee has been very active and has met on the average twice a month throughout the whole period. In addition, business was expedited by the reference of many matters to sub-committees for consideration and report, and it was repeatedly found desirable to consult the School Council and the Medical Committee. Gradually the Committee arrived at certain basic decisions. The arguments for the retention of both the Medical School and the Hospital in their present situation were overwhelming, and even the few who urged that advantage should be taken of this opportunity to move both out into the country, leaving only a casualty receiving department in the Borough, willingly accepted the proposal that a Recovery Hospital should be provided in the country while the School and Hospital were retained in the Borough, as a compromise that was entirely satisfactory.

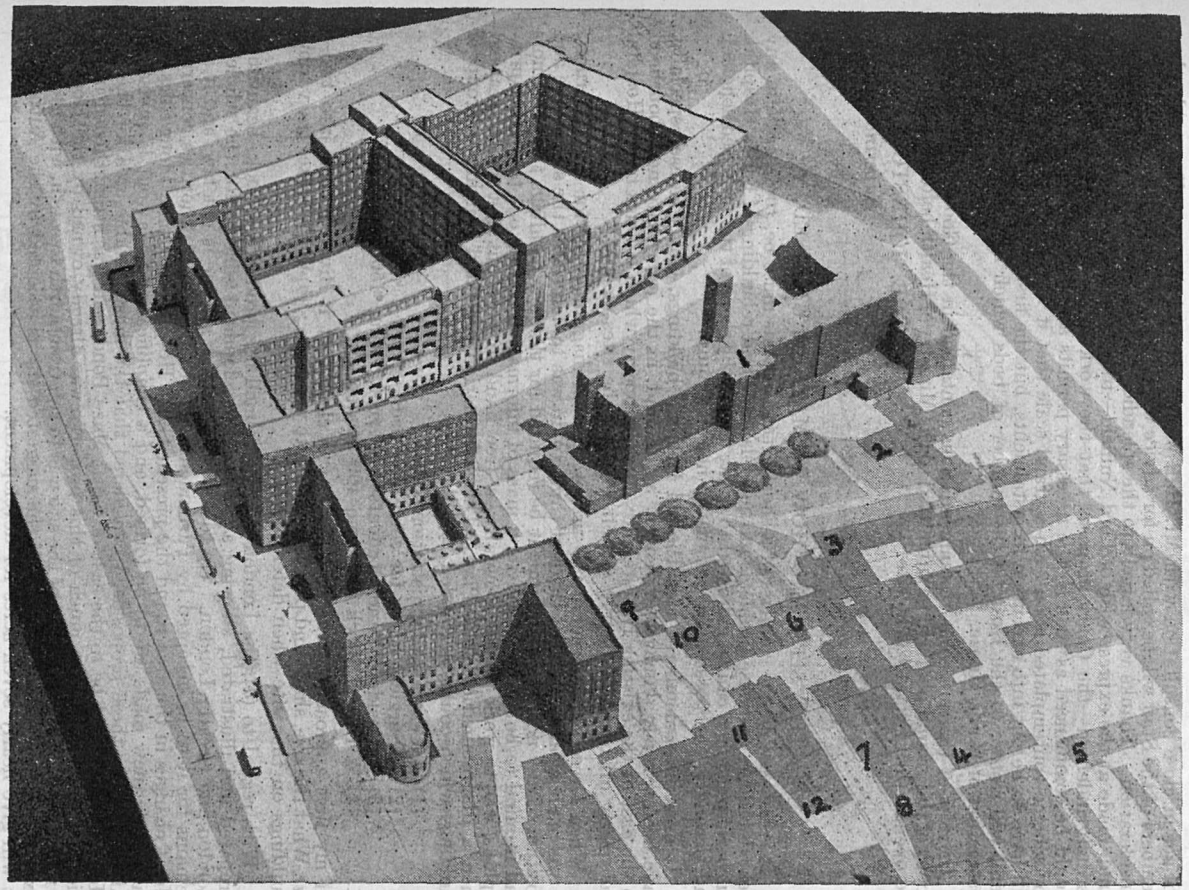
There proved to be general agreement that one thousand beds should be available at Guy's to meet the educational needs of an annual entry of one hundred medical students. Beds in the Recovery Hospital would be supplemental to this total. Foreseeing many of the recommendations of the Goodenough Report, the Committee endeavoured to estimate the amount of additional accommodation that would be required, not only for the treatment and investigation of patients, but also for purposes of teaching and reasearch. It was assumed that in all probability whole-time professorial units would be established in connection with at least three clinical departments.

A mass of data and reports was accumulated concerning the future requirements of the Hospital and was handed over to Mr. Alner W. Hall, who had been asked by the Court to draw up a ground plan to enable negotiations to be opened with regard to the site with the London County Council and the Borough Councils of Bermondsey and Southwark. At the same time Mr. Hall was informed of the intention to rebuild both the College and the Dental Department and School, and he was given a clear idea of the accommodation which would be needed in this connection. With this information at his disposal Mr. Hall has drawn up a ground plan which shows the area of the new site that will be covered. This plan determines broadly the character that the new buildings will assume, but it will be understood that the elevation shown is not intended to do more than give a general idea of the probable final appearance, and the details of the external and internal features of the building, being matters of less urgency, have yet to be considered.

Once the site has been agreed with the authorities concerned Mr. Hall will proceed to draw up detailed plans for the approval of the Court. A special Buildings Committee

KEY TO THE EXISTING BUILDINGS

1. Hunt's House.
2. Nuffield House.
3. Medical School.
4. Nuffield Nurses' Home.
5. York Clinic.
6. Raphael House Nurses' Home.
7. Laundry.
8. Tabard House.
9. Shepherd House.
10. Massage and Electrical Departments.
11. Mortuary.
12. Works Department.



THE PROPOSED NEW BUILDINGS

will act in close consultation with Mr. Hall while this work is proceeding, and other members of the Staff will be called on for advice when their own departments are under consideration. Thanks very largely to the splendid gift from King Edward's Hospital Fund, made at the express wish of Lord Nuffield—to whom the Hospital will be everlastingly indebted—the Court proposes that the work of erecting the new Hospital should be commenced as soon as the necessary permits and licences can be obtained. The scheme contemplated is on such a grand scale that it is more than likely that it will have to be put into execution in instalments, but the first instalment, when complete, will restore to the Hospital the number of beds which have been lost by the destruction of Guy's House.

In view of the numerous recommendations contained in the Goodenough Report, a copy of the ground plan will be submitted to the Ministry of Health before negotiations are opened with regard to the site.

T. B. JOHNSTON,
Superintendent.

THE SITE AND HOW IT MAY BE UTILISED.

It is not easy in the compass of a short article, as this must be, to describe in any great detail the immense problems in the replanning and rebuilding of Guy's Hospital, but perhaps enough can be indicated to show, firstly, the scope of the proposed scheme; and, secondly, the possible layout of the new buildings.

It must be remembered that the old Hospital buildings, Guy's House especially, have been severely damaged by enemy action and, in the immediate neighbourhood to the east of the existing Hospital site, much property which belongs to the Hospital has nearly all been completely demolished and the sites cleared.

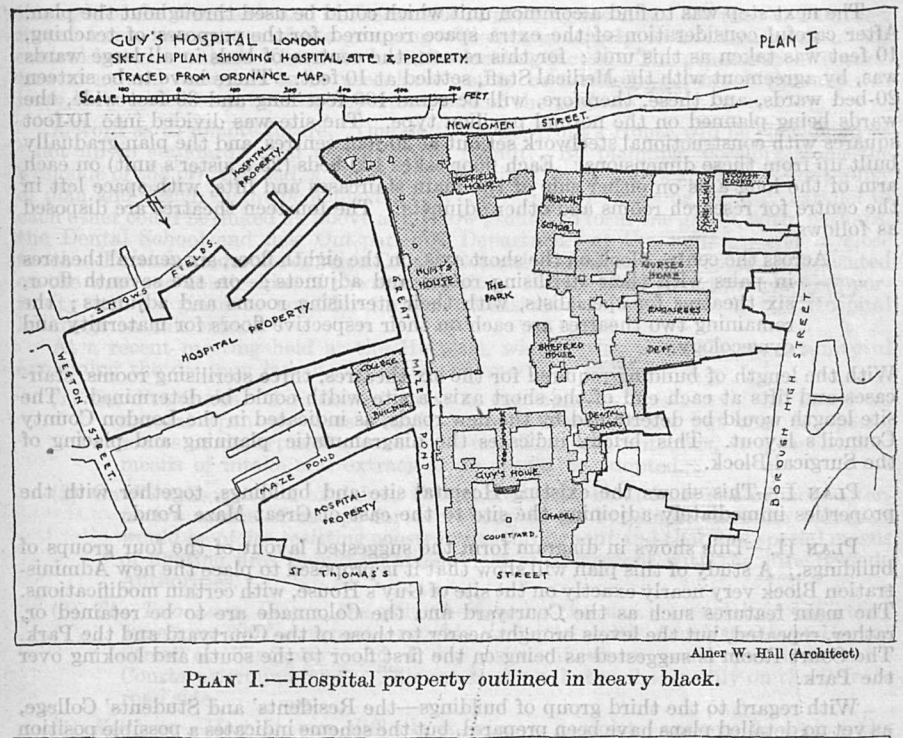
When I received instructions to prepare certain diagram plans for the Governors, it was made clear to me that the first thing to do was to determine the size, shape and position of any new site which might be required for the new buildings the Governors had in mind to build. I was given a mass of information setting out the broad principles I was to work to and, generally, a free hand to work out first a site area and then a diagrammatic Block Plan. This information indicated roughly a group of buildings which could be divided as follows :—

(1) A Central Administration Block.
(2) A Surgical Block for some 605 beds.
(3) A Residents' and Students' College for some 150 persons.
(4) A Dental Block for some 400 Students.

In my first approach to the problem it was clear that it divided itself into two—(*a*) What the size, shape and position of the site was to be ; (*b*) how to place the various buildings on that site when determined.

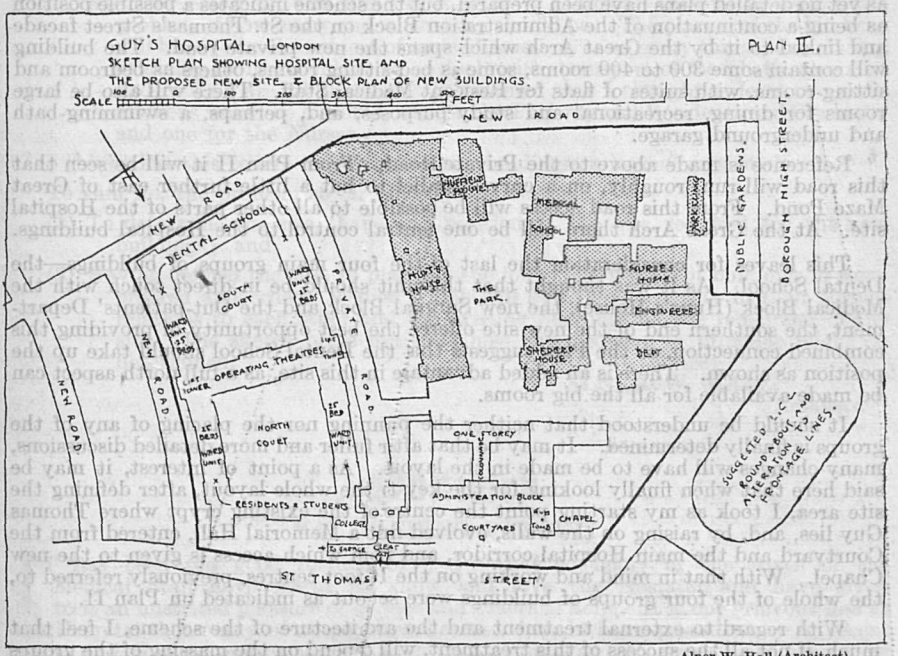
With regard to (*a*), the London County Council has produced a book, beautifully prepared and illustrated, showing a post-war development scheme for the whole of London and Greater London. Up to the moment this scheme is not law, and it still remains for it to be accepted by Parliament and other Public Authorities concerned. Great changes in the area round the present Guy's Hospital site, on all four sides, are indicated : new roads are to be formed, and a simplification of lay-out is envisaged. After studying these proposals, I considered that the most suitable area for the new Hospital site would be to the east of Great Maze Pond, and was strengthened in this view by the fact that so much of this property was already owned by the Hospital. I noted that the general trend of the site was to run from north to south, with the short axis running east and west, and, if the suggested site is accepted by the Authorities, it will give nearly seven acres for development.

A study of the Governors' requirements for the Surgical Block—perhaps the most important of the four groups—indicated that, in addition to the 605 beds asked for, 14 operating theatres were required. These have to face north, and therefore were ear-marked as being planned along the short east to west axis. This led to the planning of the main wards on the long, or north to south, axis and as this means the sunny aspect for the wards the Block began to take shape. In the memorandum dealing with the Surgical Block, the Governors laid it down that a sister's unit should consist of 25 beds, having 20 beds in one large ward and 5 single-bed wards attached, together with all the usual anciliary offices. Each large ward was to have an open balcony and each sister's unit a day room.



Alner W. Hall (Architect)

PLAN I.—Hospital property outlined in heavy black.



Alner W. Hall (Architect)

PLAN II.

The next step was to find a common unit which could be used throughout the plan. After careful consideration of the extra space required for the purposes of teaching, 10 feet was taken as this unit; for this reason, the centres of beds in all large wards was, by agreement with the Medical Staff, settled at 10 feet. There have to be sixteen 20-bed wards, and these, therefore, will be some 100 feet long and 30 feet wide, the wards being planned on the normal pavilion type. The site was divided into 10-foot squares with constructional steelwork set out at 20-foot centres, and the plan gradually built up from these dimensions. Each floor takes 100 beds (25 a sister's unit) on each arm of the long axis on either side of the main staircases and lifts, with space left in the centre for research rooms and other adjuncts. The fourteen theatres are disposed as follows :—

> Across the centre block on the short axis, on the eighth floor, six general theatres in pairs with their sterilising rooms and adjuncts; on the seventh floor, six theatres for specialists, with their sterilising rooms and adjuncts; the remaining two theatres are each on their respective floors for maternity and gynæcology.

With the length of building required for the six theatres, three sterilising rooms, staircases and lifts at each end of the short axis, a site width could be determined. The site length would be determined by the new roads, as indicated in the London County Council's layout. This briefly indicates the diagrammatic planning and placing of the Surgical Block.

PLAN I.—This shows the existing Hospital site and buildings, together with the properties immediately adjoining the site to the east of Great Maze Pond.

PLAN II.—This shows in diagram form the suggested layout of the four groups of buildings. A study of this plan will show that it is proposed to place the new Administration Block very nearly exactly on the site of Guy's House, with certain modifications. The main features such as the Courtyard and the Colonnade are to be retained or, rather, repeated, but the levels brought nearer to those of the Courtyard and the Park. The Court Room is suggested as being on the first floor to the south and looking over the Park.

With regard to the third group of buildings—the Residents' and Students' College, as yet no detailed plans have been prepared, but the scheme indicates a possible position as being a continuation of the Administration Block on the St. Thomas's Street facade and linked to it by the Great Arch which spans the new private road. The building will contain some 300 to 400 rooms, some as bed-sitting rooms, others as bedroom and sitting-rooms, with suites of flats for Resident Medical Staff. There will also be large rooms for dining, recreational and study purposes, and, perhaps, a swimming-bath and underground garage.

Reference is made above to the Private Road. From Plan II it will be seen that this road will run, roughly, on a curve parallel to but a little further east of Great Maze Pond. From this road access will be possible to all other parts of the Hospital site. At the Great Arch there will be one central control to the Hospital buildings.

This leaves for consideration the last of the four main groups of buildings—the Dental School. As it was thought that this unit should be in direct touch with the Medical Block (Hunt's House), the new Surgical Block and the Out-patients' Department, the southern end of the new site offered the best opportunity of providing this combined connection, so the Plan suggests that the Dental School should take up the position as shown. There is an added advantage in this site, as a full north aspect can be made available for all the big rooms.

It should be understood that neither the planning nor the placing of any of the groups is finally determined. It may be that after fuller and more detailed discussions, many changes will have to be made in the layout. As a point of interest, it may be said here that when finally looking for the key to the whole layout, after defining the site area, I took as my starting point the centre of the existing crypt where Thomas Guy lies, and, by raising on the walls, evolved first a Memorial Hall, entered from the Courtyard and the main Hospital corridor, and from which access is given to the new Chapel. With that in mind and working on the 10-foot centres, previously referred to, the whole of the four groups of buildings were set out as indicated on Plan II.

With regard to external treatment and the architecture of the scheme, I feel that much, if not all the success of this treatment, will depend on the massing of the groups with a gradual building up of the heights to the two great staircase and lift towers at

the ends of the short axis and in the centres of the long facades. On the St. Thomas's Street front, the success of the grouping will depend largely on the treatment of the central feature, with the Great Arch as the deciding factor. The general architectural treatment and materials to be used have yet to be decided, and much thought will have to be given to this most important side of the problem.

A word as to remote future. One day, maybe, Hunt's House will be considered as "not up to standard" and require to be rebuilt. By planning, possibly along the west side of the private road, a block on similar lines to the Surgical Block, a continuity of plan and design might be achieved, and the two blocks running roughly parallel to each other could be linked up above and below ground to form one group, with, perhaps, the Dental School and new Out-patients' Department at the southern end in close touch. Further, under the London County Council scheme, many changes are indicated on the west and south sides of the existing site. If and when they take place, opportunity will be given to consider further extensions and additions to the Hospital buildings on this side.

At a recent meeting held at the Hospital, when I was given the opportunity of explaining the diagram layout, a number of questions were asked :—

(1) On *Ventilation.* I indicated that, in my opinion, this should be based on natural open air cross ventilation wherever possible, but that in special rooms or departments, such as X-ray, Theatres, Kitchens, etc., mechanical means of intake and extract of air would be adopted.

(2) On *Fire Escapes.* I explained that there would be at least one or more alternative means of escape for everybody in all buildings, that the buildings would be of fire-resisting construction throughout and that any special means of fighting fires should be the subject of discussions with the Fire Brigade Authorities.

(3) *The Two Large Courts,* the point here being the size. I explained that they were over 200 feet square—roughly, twice the width of such streets as Regent Street or Kingsway—and I was asked if access could be given these Courts at ground level. This can be done, but probably only on the Private road side.

(4) *Kitchens.*—Here it was difficult to give a complete answer, involving the problem of how many and where they should be. The placing of the kitchens will have to be the subject of much discussion, as so many things, *i.e.*, placing of dining-rooms, numbers to be dealt with, transport of food both uncooked and cooked, are all involved. I explained that I thought at least two main kitchens would be required, one for the Patients and Residents and Students, and one for the Nurses.

I think that this covers in general terms the diagram layout suggested.

To sum up, the problem so far envisaged is two-fold :—

(1) To determine the size, shape and position of the site required for the new buildings ; and

(2) Having defined the site, to plan out the four main groups of buildings in some ordered and orderly fashion which will link them together in their correct relations to each other and the existing buildings on the remainder of the site. The sketch plans illustrate how this problem in principle might be determined.

ALNER W. HALL,
Architect.

Obituary

MAY FLEMING FAWCETT.

IT has been the good fortune of Guy's that so many of the wives of the Medical Staff have learnt to know and love the Hospital, and have given to it an unstinted measure of service and practical help. It is our grievous loss at the Hospital that many of these warm-hearted friends have passed away in recent years, and now we mourn the loss of May Fleming Fawcett, wife of our consulting physician, the late Dr. John Fawcett.

No one can know better than the Matron of the Hospital what a source of strength it is to have an active and strong society of ladies behind her who are interested in providing garments additional to the standard Hospital stock. Mrs. Fawcett, for many years, was the focal point of the Guy's Hospital Ladies' Association. A former secretary joins with me in paying a tribute to her memory.

E. E. P. MACM.

Mrs. Fawcett became a member of the Guy's Hospital Ladies' Association in 1899, and served as Honorary Treasurer 1921–1930. She was always very interested in the garments and, from time to time, as the Linen Sister requested different types of garments, she designed the patterns for these, spending thousands of hours in making every detail and every sample garment perfect. Nothing but perfection was good enough for Mrs. Fawcett, and every garment had to be "tried out" in the wards and in the laundry before it was accepted as a standard pattern. The G.H.L.A. knitting book was edited by her, and again every knitted garment was submitted to the same strict examination before being included in the book. She cut out every paper pattern personally. Every expense in the printing of the direction slips for the garments and the knitting books was defrayed by her, and she also presented the sewing-machine to the G.H.L.A. for use at the working parties. After resigning her treasurership in 1930 she held no official post in the G.H.L.A., but, always, she remained the link between the Matron and the Sisters and the Association, regarding garments most required in the Hospital. Until the war, when her house was bombed, she had care of all the materials and arranged all the cutting-out for the working parties.

By the passing of Mrs. Fawcett, the Association has suffered a grievous loss and we shall not meet her like again.

J. C. TURNER.

ON May 29th, 1944, Mr. J. C. Turner, the senior technical assistant in the Bacteriological Department, died at The Wildernesse, after some months of serious illness. It is by a sad coincidence that only a very short time after the sudden death of the late Professor Eyre we should have also to record the passing of the man who was in all technical work his right-hand man for the whole thirty-two years of his career at Guy's. Turner first took up laboratory work when as a boy he joined his late chief at Charing Cross Hospital. When Eyre returned from there to Guy's, Turner came with him and thenceforward grew up with the Department. Generations of Guy's men will remember his tall, solid, efficient figure. There could not have been a greater physical contrast between chief and assistant. But two things they had in common: quite remarkable skill in matters of technique and a cheerful helpfulness to all and sundry who sought their aid. Turner was only in his fifty-seventh year at the time of his death and was thus on active duty until quite recently. He played a great part in helping the department through the difficulties of a second war and particularly of the "blitz" period. The present bacteriologist was fortunate in having such a skilful helper at hand when he first took over and is truly thankful for Turner's unremittingly loyalty and aid during the past ten years. Turner was an active member of the Pathological and Bacteriological Assistants' Association and a sometime examiner in Part I of their Intermediate Examination. His great hobby was bowls, a game at which he excelled and won many prizes.

Students' Union

A GENERAL meeting of the Students' Union took place on September 1st, 1944, in the Anatomy Lecture Theatre. Mr. T. B. Layton was elected as the first Honorary President of the Union; Mr. I. Munro was re-elected chairman for the coming three months; and Mr. N. Macrae-Gibson was elected as the new secretary for the coming six months. It was decided that in future the elections for chairman and secretary should be held each six months, the two offices overlapping each other by three months.

Mr. Doherty, the Sub-Dean, then addressed the meeting on the shortage of clinical material and the present teaching position in the Hospital.

In January the Hospital was informed by the Ministry of Health that when the Second Front opened the hospitals in the sector would have to be evacuated, the teachers would be needed to deal with casualties, and clinical teaching would have to stop for two to three months. Fortunately this did not take place, as Kent was not used as a base for the opening of the new front.

The Germans then began their flying-bomb attacks. At the beginning of August the Ministry of Health called a meeting of the Deans of the London teaching hospitals. They were told that it had been decided to evacuate all the hospitals in the London area, the beds were to be emptied and the students in the medical schools were to be

dispersed for a while apart from the senior students. All the deans objected to this as a similar experience at the beginning of the War had resulted in no teaching for the students, who were sent away to other hospitals.

Mr. Doherty went on to say that the Guy's sector was the worst of all the hospital sectors, as it was the chief target area. We were drawing on patients from an area where the population had largely been evacuated. Consequently we were very short of clinical material.

The Ministry of Health has now decided to allow the admission of a certain number of cases for teaching purposes that could, if necessary, be evacuated at a moment's notice. In this way the teaching hospitals could be kept going for the next few weeks, when the present emergency, it was hoped, would be so improved as to need these measures no longer.

As regards the teaching situation, Mr. Doherty continued, one must realise that between sixty and sixty-five per cent. of the teachers in the Hospital were now serving in the Forces. The Staff were trying their best to improve the situation, but it was up to the students to endeavour to get as much use from any cases in the wards, and to discover the full value of the Library and the Museum. B. D. G.

Correspondence

WAR SURGERY.

To the Editor of the GAZETTE.

SIR,—I have just read with great interest Mr. Eckhoff's interesting lecture on "War Surgery," published in your issue of August 19th, 1944, and would like to emphasise one or two points he made, and make a remark or two which may be of use to men shortly to join the Service.

One point that has emerged is that cases after resuscitation should be operated on as soon as the M.O. in charge is satisfied that the case has reached his "peak"—that is to say, that his B.P., pulse pressure and general condition have been made as good as possible, because we have found often that if this golden moment is not seized the peak passes and the patient's condition begins to deteriorate again. This calls for close liaison between the Resuscitation M.O. and the Surgical Teams.

I would like to emphasise the point about not using too much heat in the Resuscitation Ward in the form of electric cradles, as this has definitely been proved to be harmful and the simple warmth of the room or tent plus blankets and, if necessary, hot bottles are sufficient. I would also say that in this C.C.S. we have discontinued the use of the classical "hot sweet tea" in Resuscitation Ward, as we found that, so often, it is returned with thanks on the table. After being wounded the patient exists on an exclusive diet of cigarettes and hot sweet tea in the R.A.P., Advanced Dressing Station and Reception Ward of the C.C.S., so that this is considered no longer to be essential in the Resuscitation Ward.

Turning to abdominals, I can confirm that these cases do not travel well and it is essential to keep them still for a minimum of a week, and often longer before evacuation. This presents one of our problems in a war of rapid movement, as we have to leave behind a small section to look after the immovables when we move forward until they are evacuated, the administration of which being one of the headaches of a C.O. at the rate at which we are advancing now. I would also like to cross swords with Mr. Eckhoff on his figures on the mortality of abdominal wounds. I am sure that his figures are on the pessimistic side and the Consulting Surgeon to 21 Army Group has been delighted at the low mortality of abdominal wounds reported from England. (His figures for June, 1944, are for all abdominal wounds with visceral injuries). Recovery: 68 per cent. While agreeing that colonic wounds are attended by a mortality rate of 50 per cent. or more, I am sure that small intestine wounds are nearer 25 per cent. than 33 per cent. mortality.

The most fatal type, we find, are the thoraco-abdominal, which have a mortality of about 70 per cent.

Another point I would like to bring out is the number of multiple wounds one gets, and the rate at which cases can be operated on is very much slowed down by the fact that one case, very often, has to have what is virtually two or three major operations

in the theatre, all of which takes time, so that the selection of operation cases or, rather, the selection of priorities, is one of the most responsible jobs in the unit, to my mind.

I must not go on at great length, but will end by agreeing that head injuries travel extremely well—we always get them back to the Head Centre quickly—and that phosphorus burns always show a marked degree of shock, which has to be considered as well as the treatment outlined by Mr. Eckhoff.

Yours, etc.,
S. C. H. LANE,
Lieut.-Col., R.A.M.C.

No. 16 (Br) C.C.S.,
B.L.A., Sept. 2nd, 1944.

Hospital Information, etc.

Notices

POST-GRADUATE INSTRUCTION FOR DEMOBILISED OFFICERS.

21st August, 1944.

Applications are invited for the post of whole-time Secretary of a Committee appointed to arrange, on behalf of the Ministry of Health, for the provision of post-graduate instruction in the Eastern Counties for medical officers released from His Majesty's Forces. Applicants should be graduates in Medicine. The salary of the post will not exceed £1,000 a year, non-pensionable, with an allowance for travelling expenses. The appointment will be temporary, and will be for one year in the first instance. Applications should be sent, before October 2nd, 1944, to the Registrary, University Registry, Cambridge.

T. S. HELE,
Vice-Chancellor.

Emmanuel College Lodge.

Would the gentleman who borrowed the copy of Smith's "Block Anæsthesia" presented to the Dental Departmental Library by Mr. T. B. Layton (and subsequently borrowed by him on January 31st, 1944), please return same without delay either to Mr. Layton or to the Dental Department?

Change of Address

R. W. B. Ellis, Wing Commander, R.A.F., No. 1 R.A.F. General Hospital, C.M.F.

J. A. T. Griffiths, M.R.C.S., L.R.C.P., Brook House, Victoria Road, Prestatyn, N. Wales.

P. G. Large, M.B., B.S., 701, Currie Road, Durban, Natal, S.A.

T. J. Mathewson, Squad.-Ldr., No. 1 G.R. Op. Unit, R.A.F., C.M.F.

Papers by Guy's Men

Mann, W. N. Hæmoglobinuria following the Administration of Plasmoquine. *Trans. Roy. Soc. Trop. Med. & Hyg.*, 1943, **37**, 151.

Douthwaite, A. H. Rheumatoid Arthritis. *Medical Annual*, 1944, p. 294.

Howitt, Frank D. Rehabilitation. *Ibid.*, p. 285.

Maizels, M. Processing of Plasma with Kaolin. *Lancet*, 1944, ii, 205.

Harvey, Warren and Others. The Acidity of Dental Cements. *Brit. Dent. J.*, 1944, **77**, 61.

Gillespie, R. D. Psychological Medicine and the Family Doctor. *Brit. Med. J.*, 1944, ii, 263.

Bradley, W. H., and Others. Homologous Serum Jaundice. *Brit. Med. J.*, 1944, ii, 268.

Douthwaite, A. H. Bismuth Treatment of Rheumatoid Arthritis. *Brit. Med. J.*, 1944, i, 276.

Warner, E. C. Principles Underlying the Causation and Treatment of Nephritis. *Med. Pr.*, 1944, **212**, 86.

Northfield, D. W. C., and Another. Intra-Oral Splint for Facial Palsy. *Lancet*, 1944, ii, 172.

Stamm, W. P., and Others. Bleeding Gums in R.A.F. Personnel: Value of Ascorbic Acid. *Brit. Med. J.*, 1944, ii, 239.

Bradbeer, W. H. Skin Grafting in Frontal Sinus Operations. *J. Laryngol. Otol.*, 1944, **59**, 36.

Hurst, Sir Arthur. Functional Diseases of the Colon and Rectum. *Clin. J.*, 1944, **73**, 127.

Stamm, T. T. The Treatment of Simple Fractures. *Clin. J.*, 1944, **73**, 132.

Smith, R.E. Mumps. *Clin. J.*, 1944, **73**, 137.

Dowling, G. B. Erythematous Lichen Planus. *Proc. Roy. Soc. Med.*, 1944, **37**, 410.

Forman, L. Pustular Bacteride with Acute Relapse following Sore Throat in a Patient with Psoriasis of the Scalp. *Proc. Roy. Soc. Med.*, 1944, **37**, 411.

Dowling, G. B. Two Cases of Lichen Planus. *Proc. Roy. Soc. Med.*, 1944, **37**, 413.

Enderby, G. H. Use and Abuse of Trichlorethylene. *Brit. Med. J.*, 1944, ii, 300.

The Services

Awards

M.C.

Captain D. J. Tibbs, R.A.M.C., in recognition of gallant and distinguished services in Normandy.

Efficiency Decoration of the Territorial Army.

Lieut.-Col. (Temp. Col.) E. C. Woodhead, R.A.M.C.

Major (Temp. Lieut.-Col.) H. H. Kenshole, R.A.M.C.

Mentioned in Dispatches.

Captain C. W. Marshall, R.A.M.C.
Lieut. R. H. Hughes, R.A.M.C.

Wounded.

Captain G. C. Kennedy, R.A.M.C.
Lieut.-Col. G. N. Wood, R.A.M.C.

Death.

Surg. Rear-Admiral G. L. Buckeridge, R.N.

Deaths

DODDS-PRICE.—On September 1st, 1944, at Camperdown, Ferring, Sussex, John Dodds Price, M.R.C.S., L.R.C.P., aged seventy-nine years.

EDS {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

IT is customary that this issue of the *Gazette* should be largely for the benefit of students entering the Hospital, be they Medical, Dental or Nursing; the contents, therefore, are possibly of interest only to a small minority of our readers, although there can be few of the more advanced students who will not gain from re-reading them. For the latter there are several excellent reviews which should be a help in their selection of literature for their studies.

We would like to extend a warm welcome to our new body of students and at the same time sympathise with them in their lack of clinical material. It is during the first few appointments especially that wide contacts with patients, the writing of their case histories, and the benefits of registrar's ward rounds are most appreciated and most necessary, and the enforced scarcity of these at this time is unfortunate; however, with the rapid advances of our forces on the Continent, we may confidently hope for better things shortly, and in the meantime the Medical School are using every device to extend the amount of teaching material. Until the present situation improves, new students may be able to console themselves in their leisure hours by exploring the possibilities of the Gordon Museum and by reading up the cases they have seen in the wards in the Wills' Library.

THE increase in the incidence of pulmonary tuberculosis amongst the younger members of the Hospital has caused misgivings in many quarters, and to offset this danger we should like to press for free six-monthly X-rays of all students, nurses and ancillary staff, a practice strongly advocated in the M.R.C. pamphlet on the Control of Cross infections in Hospitals; a limited system on these lines is in force at the moment, but its very limitations have proved it unsatisfactory, as results show. In such an important matter financial considerations should be no bar to a reasonable system for the early detection of this disease.

IT the past year or so there has been a singular lack of enterprise amongst our readers in the literary field; although paper shortage has restricted our scope to a large extent, we are still eager to print articles, cartoons, sketches, caricatures, essays or poems that are sent in to us and that are considered to be of sufficient merit. Our standards are not inordinately high and we would welcome new contributors; Who knows? There may be another Keats languishing in our midst.

WE would like to draw attention to the article on the Clubs' Union. Guy's has always had a high reputation in all fields of sport and it devolves upon the present generation of students to further this to-day; there is no reason why any interested person should feel himself excluded from the particular form of athletics that he favours, and if he has missed the lists posted in the Colonnade, no false modesty should prevent him from applying to the secretary of the game concerned, who will, we are convinced, turn an attentive ear.

MR. T. B. LAYTON will give an inaugural address to the Students' Union in the Physiology Lecture Theatre on Thursday, October 12th, at 4.15 p.m.; he will speak on "Guy's and the White Paper."

WE regret to note that our cricketing correspondent has fallen into the unfortunate phraseology of the sporting columns in the popular Press.

The Clinical Period in War-time

OWING to the small number of beds available for patients at Guy's, it is necessary for a number of the students' appointments to be held in the Emergency Medical Service Hospitals in Sector 10.

It may be useful for those now entering the wards to outline the distribution of these appointments.

Owing to the fact that students are now permitted to sit for the first part of their final examination after twenty-four months in the wards and to qualify in thirty months, it has been necessary to rearrange the curriculum and combine some of the appointments.

The first three-month appointment undertaken on entering the wards is now a combination of the old pre-clinical period and surgical ward clerk; this is done at Guy's, as is also the next three-month appointment of medical ward clerk. During the six months the student (first three months) attends courses in elementary pathology and bacteriology and has an opportunity of joining in the various other activities at the mother hospital. The next two appointments, each of three months—*i.e.*, junior dresser and medical ward clerk (second three months) are held at the County Hospital, Farnborough, with some extra teaching at the E.M.S. hospital at Orpington.

The student now returns to Guy's for the three months' "free period," when his time is filled up by appointments in the eyes, skin and V.D. departments and instruction in fevers, vaccinations and the administration of anæsthetics, etc.

The study of midwifery, gynæcology and children's diseases occupy the student for the next six months, which is spent either at the County Hospital, Farnborough, or the County Hospital, Pembury. A fortnight of this period is spent in residence at Guy's, whilst doing a term of duty in the labour ward.

The student now returns to Guy's again, where he does the compulsory appointments of dresser in the Ear, Nose and Throat Department and senior surgical dresser. During this time he has an opportunity of attending general out-patient departments and gaining practical experience in the wards and the Surgery.

Appointments in the special departments, several of which can be held conjointly are now available for students who have completed the compulsory curriculum. The Out-patient departments of all these specialities are at Guy's, but the In-patient work is mostly done in the Sector Hospitals, and the student is advised to visit these as often as possible.

Every student should, at the beginning of the clinical period, visit the medical school office at Guy's and review broadly his plans for filling in courses of compulsory lectures at Guy's and elsewhere with his proposed appointments in the Sector hospitals.

To Those Entering the Clinical Period

BY DR. A. H. DOUTHWAITE.

YOU are now exchanging the routine of arduous pre-clinical studies, interspersed with generous holidays, for the enlivening experience of working for sick people. If you have chosen your career rightly you will never have to complain of monotony, but you will at all times be over-worked, and the nearer you approach qualification the shorter will be your periods of leisure. No matter what schemes may be devised to guarantee a living for the indolent, there will never be a place in this Hospital for the type of student who avoids all duties save those which alone help him to pass his final examination. If you aim at becoming competent doctors you must apply yourselves with enthusiasm to your tasks from the very first. In short, work as you have never worked before. Imagine always that you have sole responsibility for your cases. Picture to yourselves what ought to be done, and decide which of these investigations you are

capable of doing unaided. Then, with the permission of your house-officer, do them. You will learn more in three months on these lines than you would in five years of formal lectures.

As to the planning of your studies, last-minute cramming for final examinations is of no use. The subject is too vast for anything other than gradual absorption, so it is well to follow some plan from the outset. The Preliminary Clinical Period prepares you thoroughly for the routine examination of patients, and thus prevents waste of time when you enter the wards. Beds and their human contents are allotted to you, and *therewith your share of responsibility.* The taking of the medical history is the most important step towards arriving at a diagnosis. This is primarily your job, and its value cannot be over-emphasized, though too often forgotten in a desire to search for physical signs of disease. The ability to sift the relevant facts from matter which obscures can only come with experience. In the meantime, bear in mind the value of facts, as opposed to patients' interpretation of them, and of their presentation in a legible, and, where possible, schematic, form. When writing a report, do so with the thought that on its accuracy may depend the outcome of valuable research undertaken years later. Whenever possible, examine your patient before he is seen by the registrar, and commit yourself to a diagnosis. Progress of the disease, its outcome, treatment given, opinions expressed on diagnosis, should all be entered to make the records of lasting value. Write down your findings and conclusions. It is the only way to avoid that type of mental dishonesty which leads to brilliant differential diagnoses any one of which can be claimed as a personal success at a later date ! This dangerous habit once acquired is difficult to discard. It meets with but scant respect, however, from the relatives of the sick. Mistakes have a high educative value. They snatch one with a jerk from the danger of self-complacency.

Probably the best plan of study is to concentrate for the first three months on pathology. This entails, of course, frequent visits to the post-mortem room. Given this grounding, symptoms and signs become the natural expression of the disease and their memorising is unnecessary. The most valuable time of the day for the acquirement of practical knowledge is that which follows the afternoon round. It is then that the house physician performs lumbar punctures, collects blood, taps chests and so forth. These procedures should be watched and from time to time you will be given the opportunity of carrying them out yourself. It is now, also, that special signs referred to in the teaching round can be re-examined and thus fixed in the memory. It should be made a point of pride that within a fortnight you should be able to inspect the optic discs of any patient you may choose. Once the knack has been acquired, and it usually comes quite suddenly after several days of disappointment, it will never be lost. It takes many months to be certain of the normal as opposed to the diseased disc, yet recognition of early change may be of the utmost importance in determining a diagnosis and possibly even in saving a life.

The patients in your beds will confide in you possibly more than in the house officers or staff. To them you are their doctor and from you they will try to get confirmation of their fears in respect of illness, or of suspicions in relation to earlier treatment. An immense amount of mischief is caused by the making of unguarded remarks which can be misconstrued. Their avoidance is doubly difficult in a teaching hospital, where a discussion on the problem is too often carried out within earshot of the patients. We all err unwittingly in this respect, and the importance of discretion needs reiterating. The fact that a patient can inspect his own report is deplorable and should be remedied.

Attend Out-patients' when you can. This is the only hospital activity which remotely approaches the conditions which obtain in general practice. The frequent absence of physical signs may be tedious, but precisely for this reason is the experience invaluable in forcing you to rely more and more upon history-making. It is an antidote to the poison of mechanised medicine, whose virulence increases with every new instrumental aid to diagnosis.

Insure your life and health, and join a society for protection against legal action as soon as you are qualified.

In moments of despondency remember that Medicine is the only profession which never provides two days alike, and in which boredom is a rarity.

The Dental Curriculum

By F. BOCQUET BULL, Sub-Dean of the Dental School.

ONCE again a school year is commencing, and to all new dental students a sincere welcome is offered. With this welcome is coupled the hope that before you have been students here for any length of time your work and study will be carried out in pleasanter circumstances than have been the lot of the students for the past five years.

Your acceptance as students of the School has placed you in a reserved position, but that reservation carries with it a condition that you must make satisfactory progress. To do this means diligent study without slacking and a full and proper realisation of the fact that by working hard you are only, after all, carrying out conscientiously your side of a contract. The fulfilment of this obligation depends entirely upon you and the spirit in which you carry it out. By conscientious work in honouring the trust imposed upon you, you will bring credit to yourself and your School; by abuse of this trust, the reverse.

By this I do not mean all work and no play, for this will only lead to staleness; but when you work, work hard, and when you play, play in the same manner. Keep a proper balance between your work and recreation, at the same time not forgetting that, at the present time, work is at a premium; leisure at a discount. Work and play in this spirit and your years at Guy's will prove to be some of the happiest of your life.

The motto of the Hospital is *Dare Quam Accipere*, and the Hospital and School gives freely and willingly of the very best to all students and, in return, expects to receive the very best from its students. It is true to say that in the past this reciprocity has rarely failed; and it is partly for this reason that the name of Guy's and all that is associated with it stands in such high repute the world over.

Where words have to be limited it is unnecessary for me to bother you here with advice as to your actual programme of studies, except to say that at any time that you are in difficulty in this and other respects do not hesitate to seek advice from the Dean or Sub-Dean or other officials at the Medical School Office.

The courses of study will be found in full detail in the Prospectus of the School, which, if you have not a copy already, may be obtained at the Medical School Office. All students should make themselves acquainted with the contents of the Prospectus for therein are to be found the Regulations respecting students with which all students should be familiar, and much other useful information, the possession of which may save much time and trouble. And so a hearty welcome and good luck.

To Those Entering the Nursing Profession

AT the beginning of this sixth year of war the Nursing Staff, together with other departments of our Hospital, are full of hope and plans. Matron has been talking to the nurses of the rebuilding schemes and of the reconstruction of the nurses' training. The Block System is the keystone of the educational reforms which are to take place in the near future.

There are five hundred nurses in training at Guy's at the present time, surely a school which will continue to carry on the traditions of a very worth-while profession. To those five hundred—and to others joining them—as they pass from the Preliminary Training School we give our best wishes for a profitable and happy time with us. We hope they will often think of our Hospital motto, "*Dare Quam Accipere*," knowing that no school can go forward and progress in the right way unless supported by the loyalty and true service of every individual in it.

After the five years of upheaval due to wartime conditions the transition period will not be easy and things will not right themselves without much patience and inspired leadership.

Guy's Nurses' Training School needs the constructive help and hard work of every Guy's nurse in the next few years. H. M. G.

Guy's Hospital Clubs' Union

OWING to the limitation of space it will not be possible in this special number of the *Gazette* to give a full survey of the activities of the Clubs' Union. Nevertheless the changes brought about by war conditions demand that the present status of the Union be fully understood.

For upwards of fifty years the affairs of the various clubs and societies have been under the partial control of the Clubs' Union Council, a body consisting of staff and students in whom is vested the power to allocate material or financial aid to one or other club as is deemed fit. The amalgamation has the great advantage in that it simplifies the collection of subscriptions which before that time had been a complex, if not a hopeless, business. Nowadays one subscription only is levied and this carries with it membership of any or all the constituent institutions (as are listed below), a free copy of the *Guy's Hospital Gazette* and the full use of any of the Clubs' Union premises, in particular the athletic ground at Honor Oak Park.

A second advantage is that the central control of the funds allows a fair distribution to be made to each club, whether the membership be large or small, and ensures continuity of purpose when it might otherwise be endangered by lack of support such as is always liable to occur when the more active members become qualified and leave the Hospital. As a result the years have seen a gradual growth in the number of its constituent bodies and the exploits of Guy's men in the field of sport are justly renowned.

It will be seen that membership enables the student to broaden his outlook both in the athletic and educational worlds. For those interested in sport exceptional facilities are available for increasing their proficiency, whether in a friendly game or an organised match. Fixtures have, of necessity, been curtailed since all unnecessary travel has been cut out and many opponents have had to close down for the duration of the War. None the less, the various secretaries should be congratulated in overcoming these difficulties, for, by arranging inter-hospital matches and games with representative teams of the three Services, an entertaining list of fixtures has been assured.

The Physical and Dental Societies provide opportunities for students to air their views on medical or dental matters. At these meetings cases from the wards are shown, controversial opinions expressed and from time to time papers are read on subjects of general interest. All members are strongly advised to support these societies both for the advancement of their knowledge and for the chance they offer of taking part in the discussions. The Debating Society gives similar opportunities; there is practically no restriction on the topic discussed and, though its activities have been rather quiet of late, it is hoped that it will blossom forth this winter.

One of the most important bodies of the Clubs' Union is the Students' Club. Its purpose is to provide ample accommodation for students in their moments of leisure and newspapers, periodicals and journals in so far as funds will allow. A large room in the Old Pathology Block has been converted into a reading-room and the necessary furniture provided. The original reading-room in the College was destroyed during the air-raids.

At Farnborough, rooms have been set aside in "Summerlands," and at Pembury a hut has been erected in the hospital grounds.

It is not possible in this number to review the manifold activities of the various clubs during the past year, and the reader is referred to a similar copy of the *Gazette* published on October 18th, 1941. This may be obtained from the Wills Library at Guy's on application to the Librarian. Therein will be found details of the arrangements made by the various clubs as they affect the student in the particular area in which he finds himself. The majority hold good to-day and, at the request of the Editor of the *Gazette*, it is proposed only to give a list of secretaries who will be pleased to supply further details as regards grounds, changing accommodation, fixtures, etc., on being approached by interested members.

The new student, on obtaining membership of the Clubs' Union, is strongly recommended to watch the notice-boards in the Colonnade at Guy's, in "Summerlands," Farnborough and the students' hut at Pembury, where information regarding meetings and practice games will be posted.

For all the above advantages and many more not listed the annual subscription now stands at four guineas, payable in October of each year.

All students who wish to enter fully into the life of Guy's are earnestly advised to join.

Below is a list of secretaries now to hand. Apologies are made for any inadvertent omissions :—

AFFILIATED.

Association Football Club	M. J. L. Sykes
Athletic Club	——
Boxing Club	C. H. Kinder
Boat Club	——
Cricket Club	L. D. Carton-Kelly
Debating Society	——
Dental Society	P. Maxwell Stephens
Golf Club	——
Hare and Hounds	G. F. Vaughan
Hockey Club	B. H. de C. Prideaux
Lawn Tennis Club	K. Y. Khong
Physical Society	——
Rifle Association	——
Rugby Football Club	A. Batty-Shaw
Sailing Club	D. J. Reid
Students' Club	S. H. Wass
Squash Club	P. S. Carton-Kelly
Swimming Club	R. Iliffe

UNAFFILIATED.

Christian Union	J. R. Burt
Students' Union	B. D. Grant

F. R. KILPATRICK,
Hon. Secretary, Clubs' Union.

Senior Training Corps

THE University of London Senior Training Corps is represented in Guy's by two Companies—one Medical and one Infantry.

The Medical Company (No. 4 Coy. U.L.S.T.C.), commanded by Major J. Whillis, is open to students who already have Certificate "A" and who wish to proceed to their Certificate "B" (Medical).

The Infantry Company (F. 1 Coy., U.L.S.T.C.), commanded by Captain E. W. Baxter, prepares candidates for the Certificate "A" Examination with a view to their proceeding to the Medical Unit, though there are facilities for a small number of candidates who wish to remain in the Infantry Unit and study for Certificate "B" (Infantry).

In both Companies training commences in the Winter Term and is spread over the year with a break before the Summer Examinations. Training is completed at the Annual Summer Camp, which lasts a fortnight, and at which the Certificate "A" and Certificate "B" Examinations are held. Attendance at camp is therefore compulsory.

Although it is the policy of the School to encourage men to join the S.T.C., especially if they have previous J.T.C. or other experience, men are taken in only on a volunteer basis and are only accepted providing that they show keenness, live within a reasonable distance of London, so that they can attend all parades, and that they reach the required standard of physical fitness at the medical examination.

Further information may be obtained in the Medical School Office.

Guy's Letter

SINCE the last Guy's letter was published the successes of the Allied Armies have been enormous and not without local repercussions. All but two of the housemen have returned to Doyle's to sleep, and "The Shades" is now used solely as the almoners' cloakroom once more. Those two had never been driven so low—come what might! "D" Floor, in Nuffield House, is used at night again, and one can move more easily along the corridor on the ground floor of the Nurses' Home (or so we are told)!

We were all sorry to let John Morgan and Paul Crisp go; they are now in the Army. Mike Cutler went off sick (though he has now recovered, but not returned). The various vacancies have been taken by Angus Macrae-Gibson, Sidney Hilton and Bobby Irvine, with Crabb as dental house-surgeon. It is too late to welcome them as they are now stolidly entrenched.

There has been a revival of social activities, and a treasure hunt and scavenger hunt were organised with the Home as headquarters. Gramophone concerts have also been restarted there. The residents have been able to entertain their friends to dances held in their newly allocated lounge in the Pathological Block. It is to be hoped that it will soon be possible to arrange larger dances in the less restricted space of the Nurses' Home.

We have been told that sand-grouse on the Nile delta make an impressive sight. Recent promiscuity among the starling population seems to be achieving a similar local success. It is gratifying to feel that the Hunt's House chimney (or tower) is appreciated by these birds, though, of course, it is still religiously shunned by the more self-respecting pigeon !

D. R. S. S.

Farnborough Letter—August

THE six to seven weeks since the last Farnborough Letter has seen the advent of the " flying bomb " and, as elsewhere, it forms the main topic of conversation. Apart from the usual broken windows the only gross effect is to drive the staff to shelter at night. Every night one may see a long procession of forms garbed in anything from old plimsolls to riding breeches filing into the giant brick superstructure, to emerge in the not-so-early hours, battered and bleary, the cynosure of neighbouring porters and nurses, as each makes a concerted rush to the bathroom.

Few staff changes have occurred recently. Finney is back in the fold, having served time at Gravesend ; whilst Brittain is here to help out the Maternity Department. We would congratulate Brittain on his recent marriage.

Bitter war has been declared on the masses of hostile wasps here, and repeated salients by the resident anæsthetist have resulted in the destruction of ten of the enemy camps, but camouflage has temporarily defeated our valiant forces. Gas and poison are amongst the secret weapons employed, bombing being ineffective in the deep shelters of the orchard !

With the evacuation of the Mother Hospital some Guy's nurses have arrived to maintain the rapidly diminishing numbers already here. There are great plans afoot for the evacuation of patients ; we hope that the green " *Incontinent* " labels are affixed to the right cases in the rush.

Social events are lacking because, we are told, of the menace of the bombs !

PEE-BEE.

[With apologies for its late inclusion partly for security reasons.—ED.].

Dental School Notes

THE first sign of the Dental School reaction to the flying-bomb was the appearance of the gold doodle-bug, about an inch and a quarter long. It was not, perhaps, symmetrical, or made exactly to scale, but was a tolerable representation, was highly polished and mounted on a gold pin. They were extremely difficult to carve, to shape in the wax, and one could not afford to do too much shaping after they were cast.

The time for this entertaining hobby was provided by the many appointments which were not kept ; patients were working on the hypothesis that care lavished on the teeth might possibly be wasted, and they did not seem willing to take the risk. Gas sessions formed an interesting study in psychology. As the shuddering roar of the bomb ceased, one eyed O.C. extraction and O.C. anæsthesia, and envied the patient, lying peacefully, albeit a trifle blue, his spirit surf-riding on Waikiki beaches. The large windows, formerly appreciated for the light they allowed, took on the character of Mr. Hyde, and metamorphosed faster.

Dental students took over roof-spotting for the Hospital on two days of the week ; the moan of the siren would find an empty stool, an empty cavity, a bewildered patient and a panting fang farrier pounding up the stairs to the roof of Salomon's Centre. The switch up there had a fascination ; press it and the Hospital ran. The sense of power, the height and the freshness of the breeze combined to make a welcome change from

the civilised environment of the conservation room, until one secretly began to hope that the siren might sound during the allotted hour.

During alerts, patients for conservative work were treated in the Denture Room; the change-over was depressing. The lighting there, which used to seem sufficient for matching shades and fitting dentures seemed no more than a dusk after the brightness of the conservation room with its acre of glass. One had to heave cabinet and engine down the stairs, wait for a chair, cut a cavity (with the saliva ejector immortalising Canute), run upstairs to fetch a house-surgeon, run up again for the filling materials, and insert a filling which both patient and dresser felt might have been better done under better conditions. Both, however, accepted such fillings as one of the minor horrors of war.

The Children's Department migrated to the Phantom-Head room after a week of hustling patients away from the windows; the chairs were man-handled in pieces down the back stairs by enthusiastic (?) dressers, and shop was set up overnight. The enthusiasm of the dressers may be gauged by the fact that although the department has now returned to its old haunts, the chairs remain downstairs, shrouded in dust-sheets.

We would like to congratulate P. J. Hill on winning the "plum" of the year—the Newland-Pedley Prize in operative dental surgery. J. B. K.

Reviews

Cunningham's Text-book of Anatomy. Eighth Edition. Published by Oxford University Press. *Price* 60*s. net.*

THIS book is difficult to review as, being written by several collaborators, it is not possible to give an impression of the book as a whole and still provide a fair criticism of the many different sections.

The main impression of the book is that it is at pains to emphasise the changes in position of the living, normal organ with the "anatomical position" of the organ in the cadaver, to which end many diagrams and X-ray photographs have been allied to the text.

In the parts of the book devoted to embryology it is very irritating to have to read the primary development of an organ in the main section on embryology and then to have to follow its further development in the section devoted to the anatomical description of the organ.

In the section on the central nervous system there has been a clear exposition of a difficult subject. Attention has been given to clarifying the connections of the cranial nerves. There is a very helpful sub-section on the cerebellum in this part of the book, in which the diagrams have been constructed in such a way as to explain the gross anatomy particularly well.

In the section on myology, photographs of muscles in action have been included. It is an appreciable advantage to have these in the section related to the muscles, and not, as is often the case, in the section on surface anatomy. Some of the pictures, however, appear to be deliberately posed, whereas it might have been better to show the performance of some normal action.

Lastly, two inaccuracies: In diagram 1215 the position of the radial nerve as drawn does not tally with the description in the text. In the description of the female ureter on page 708, mention is made of the fossa ovarica; no explanation is given, and there is no further reference to the fossa in the text except indirectly elsewhere in the section; nor does the above term appear in the index. P. F. M.

Elementary Morphology and Physiology. By Dr. J. H. Woodger. London: Oxford University Press, 1943. Third Edition. Pp. xvi + 522. With 269 figures in the text. *Price* 15*s. net.*

DR. WOODGER'S excellent textbook for the first-year medical student needs no introduction to teachers of biology, who will welcome the arrival of this third edition. Despite the fact that this book is always recommended both to the new man fresh to biology as well as to those who have already done a routine course

at school and who need the subject presented in a fresh and stimulating way, the average medical student still persists in choosing the " cram " book in preference to a book such as this which demands something more than just a casual acquaintance with the names in heavy type.

If a student has any doubts as to the value of the study of biology as part of his medical curriculum he should read both the Foreword and Introduction of Dr. Woodger's book with care and be prepared to act upon the advice given there.

The third edition has had a new chapter added which deals with the cockroach. The description is clear (except in the matter of the tentorium) and includes the findings of recent work on the nature of the exoskeleton, the physiology of respiration, and origin and function of the excretory organs. The chapter concludes with some remarks on other members of the insect order which are of medical importance.

It is a pity that while the opportunity presented itself the revision of the remainder of the book was not more extensive. For example, the accounts of mitosis and meiosis together with their illustrations could well have been brought up to date, likewise the account of the development of *Amphioxus* and the frog.

It is suggested that the outline drawing of the anterior end of the nervous system of the earthworm should be supplemented with an illustration such as that of Hess, where the nervous system is seen from the side and the distribution of the nerves shown. In Fig. 71, which is new, the structure labelled *d* is surely not the oviduct but the ovisac (which lies at a higher level than the funnel and does *not* open into the oviduct, although stated to do so in the text). Figs. 149 and 183, although only diagrams, are not good and want redrawing, and a separate diagram of the organ of Corti would improve the account of the mammalian organ of hearing.

The short bibliography at the end of the text enables the student who wishes to have a more detailed knowledge of any branch of the subject to seek his information in the right places. The index is also a glossary and gives derivations of many terms of Greek and Latin origin—a useful feature whch is often overlooked.

The book is now printed on clay-coated paper, which is an improvement.

E. W. B.

Pocket Surgery. By P. H. MITCHINER and A. H. WHYTE. Published by J. & A. Churchill. *Price* 10*s.* 6*d.*

IN their introduction to this little book the authors point out that it is written primarily to fill a gap which has been felt by many Service M.O.s who may have lost touch with much of the purely clinical side of their training. Certainly to a man who has had a fairly wide knowledge of his subject, and who, owing to various circumstances, cannot gain access to larger works, this volume might be of great service. Based as it is on one of the well-known larger text-books of surgery, the subject-matter calls for little criticism, beyond those differences of opinion on certain subjects which are bound to arise in a subject such as surgery. No doubt the section on gynæcology is included, as far as the Service M.O. is concerned, for the sake of completeness.

The authors go on to point out the danger, and futility, of thinking that such a book as this can replace the larger text-books in the education of the young doctor. In making this remark, can it be that the authors have noticed the regrettable change of outlook prevalent among some medical students to-day ?

Under present war conditions the life of the medical student is more unsettled than in pre-war days. With the scattering of medical schools and with the evacuation of patients over a large area of country, the medical student is often constantly moving about, never settling for long in one place. He is asked to qualify in a shorter time ; he is often asked to live in quarters lacking many of the home comforts to which he is accustomed ; in some cases these conditions lead to increased financial worries. But can all these factors be an excuse for the attitude which is becoming more and more noticeable—an attitude which may be summed up : " I've paid my fees ; now get on and get me through my exams. " ? More and more frequent are the demands for long series of systematic lectures ; more and more incessant are the demands for " spoon-feeding."

Medicine (using the term in its widest sense) is not learnt by sitting and listening to one lecture after another—even assuming one keeps awake the whole time ! Examinations must, unfortunately, always loom large in the mind of the medical student. Perhaps large series of lectures may help him to pass some of these, though

well-conducted clinicals and vivas will soon show up the man who has been purely "*spoon-fed.*" Medicine can only be learnt properly by seeing and finding things out for oneself under the *guidance and help* of one's "tutors." To learn and absorb the subjects in this way calls for initiative and private enterprise, to say nothing of efforts on the part of the student. With the disturbing influences under which he lives today, these qualities are required to an even greater degree.

Initiative and enterprise are attributes already threatened with extinction under the cloud of State medicine which hangs over us. The future of British medicine looks black indeed, if these qualities are not to be found among those entering the profession. Herein lies the danger of the "Pocket" series of text-books. To the conscientious student who has learnt his medicine in the right way by "looking and finding" for himself, this type of volume may be of great service in those nerve-racking days before his final examinations. They may enable him to "piece together" and orientate correctly what he has learnt. To the other type of student, however, with his lazy and slack mind, what a temptation to think he can learn all he needs to know from a book the size of a popular novel—and what a disappointment when, a few days after the examination, a letter arrives: "We very much regret . . ." !

D. M. S.

Modern Treatment Yearbook, 1944. Edited by CECIL P. G. WAKELEY, C.B., D.Sc. F.R.C.S. Published by The Medical Press and Circular, London. Pp. viii+211. 17 Plates. 15 Illustrations. *Price* 15*s.*

THIS tenth volume of a now well-known series contains twenty-one monographs on various common medical and surgical diseases and a further section of an equal number of authoritative articles on war medicine and surgery. The majority of contributions are explicit, practical and of unquestionable value to the practitioner and senior student. Here and there the reviewer was forced to pause and wonder. Thus Lockhart-Mummery states his belief that for ulcerative colitis "appendicostomy should be performed in all serious cases accompanied by acute symptoms, if a few days of medical treatment does (*sic*) not give prompt relief." Warren Crowe has been singularly fortunate to be able to write: "Any form of chronic rheumatism in its early stages is comparatively easy to cure." Although his faith is still pinned to vaccine treatment he allows of the use of gold only where vaccine in minimum doses is not tolerated. The puzzling statement follows that after a few doses of gold ordinary vaccine can often be resumed.

Arthur Ewens provides a chapter on staphylectomy for the control of "colds" and sinusitis and modestly supplies as subtitle, albeit in brackets, "An epochal anti-catarrhal innovation." For the uninitiated I should explain that staphylectomy is removal of the uvula. The results of this operation are freer nasal ventilation, reduced susceptibility to "colds," and prompt relief from painful sinus involvement (maxillary and frontal). To explain the alleged benefits of staphylectomy he writes that the uvula provides an ideal bacterial nidus, yet in the next paragraph declares that, unfortunately, it does not openly reveal its pathogenic identity. Like a catalyst it exerts its provocative influence without itself being materially affected. "Thus has its complicity in man's peculiar catarrhal susceptibilities been shielded from detection and a major clue to the baffling mystery of colds impenetrably concealed." Come, come, Dr. Ewens. A plate showing seventy-two uvulæ testifies to the author's industry, but is redundant in view of the bibliography giving twenty references, all to literature from the pen of Dr. Ewens.

Noteworthy for excellence are the monographs on treatment of malaria and black-water fever by Murgatroyd; vaginal discharge, by Bourne; treatment of carbuncle, by Wapshaw; and the whole of the section on war medicine and surgery. The editor's contribution on blast injuries is most interesting and well presented. A. H. D.

Fundamentals of Psychiatry. By EDWARD A. STRECKER, M.D., Sc.D., F.A.C.P. Published by Medical Publications, Ltd. *Price* 12*s.* 6*d.*

LATELY it has become fashionable to write short text-books of psychiatry and, since the begining of the present war, many such books have appeared on the market. Too often they are nothing but a rehash of one of the standard works and not worth the time spent on reading them. Occasionally one comes across a sincere attempt to provide a practical, up-to-date handbook which will give both doctors and students a workable picture of the field of psychiatry. This can be said

of Dr. Edward Strecker's "Fundamentals of Psychiatry," issued by Medical Publications Limited.

Although clearly influenced by the teachings of Adolf Meyer and the psychobiological approach to the understanding of personality difficulties, he has managed to adopt a fair, critical and commonsense attitude towards the views of other recognised authorities. His chapters on ætiology and classification of mental diseases suffer from the usual defects found in any text-books which attempt to bring order to this aspect of psychiatry, but, at the same time, he has succeeded in giving the student a broad understanding of the dynamic factors and the part they play. It is regrettable that he fails to develop this conception as much as he might in his discussion of the functional psychoses and psychoneuroses. His approach to history taking, methods of examination and formulation of findings is to be recommended for its concentration upon what is important without sacrificing completeness.

In conclusion, it is very gratifying that in his chapter, "The Psychiatry of the War," he frequently refers to the work of British authors and quotes extensively from the published works of R. D. Gillespie in this field. A. MacL.

The Work of an Almoner's Department. (Social Service in a General Hospital.) By Dorothy Manchee. Ballière, Tindall and Cox. First Edition. *Price* 6s.

MISS MANCHEE'S very full and comprehensive presentment of *The Work of an Almoner's Department* should be a useful guide and reference book for anyone working in a hospital, or outside the walls, who is interested in medico-social work.

She has collected into her small volume an amazing mass of information both on the social problems and their best line of approach, and on the medical side in the implications of diagnoses with which an almoner should certainly be familiar, though on this point it might be advisable to warn beginners that though an almoner should take every opportunity to understand the medical side of her problems, she, as an almoner, should never have an opinion on a medical matter.

Miss Manchee's real and inspiring enthusiasm is admirable, but how far direct personal case work and home visiting is advisable in an almoner's office is an open question.

Since the patient can only be helped as a unit within the family unit, and only helped adequately by a social service which is intimately acquainted with his environment and able to keep in friendly touch for as long as necessary, it would appear more satisfactory to refer all possible cases to the appropriate organisation and reserve for direct personal service those exceptional ones that can be helped in no other way.

No hospital can, or should, maintain enough almoners to give adequate continuing service to the crowds of patients from many and various localities who attend large London hospitals, and rather than a futile multiplication of almoners to add to the already large band of visitors, a strengthening of these local organisations by close co-operation and interchange of views and information would seem in the best interests of the community. E. A.

Treatment by Manipulation. By A. G. Turnbull Fisher. Published by H. K. Lewis. 4th edition. *Price* 16s.

THIS is a new edition of a book which concerns itself wholly with one part of orthopædic treatment—namely, manipulation—to break down adhesions in and around joints. The pathology of adhesions is mentioned and then the technique of manipulating joints is described.

The technical part is good, but the attached clinical side falls below that level. Hallux valgus is still attributed to badly-fitting shoes, and the condition of prolapsed intervertebral disc is barely mentioned. The author's chief illustrative case of lumbar adhesions appears without doubt to be a "disc."

Early movements of affected joints to prevent adhesions is strongly advocated, to the extent of advising knee movements the day after meniscectomy.

This book certainly clearly and correctly advises on how to manipulate, but not so clearly or correctly why to do so. A.F.R.

Practical Anæsthetics. By J. Ross Mackenzie. Published by Baillière, Tindall and Cox. Pp. viii 136. 63 Illustrations. *Price* 10*s.* 6*d.*

THE tuition of students in the art of anæsthetics leaves much to be desired. The newly qualified has to learn for himself at the expense of the patient, often with nobody to whom he can refer for knowledge and correction. It is in just such cases that a book of this nature is so useful—extremely practical, comprehensive, and not a mere litter of figures and facts.

There is a wealth of sound practical directions in its 130 pages, and it is up to date, with notes on the famous Oxford vaporiser and cyclopropane.

Chloroform and premedication (both of which are frequently misused) are, fortunately, well dealt with.

Those pursuing the subject further will find good references at the end of each chapter. W. J. S.

Minor Surgery. By R. J. McNeill Love. Published by H. K. Lewis and Co., Ltd. Second Edition. *Price* 15*s.*

AS the author himself remarks in his Preface, it is difficult to know where to draw the line in writing a book on minor surgery. As a rather arbitrary definition we tentatively suggest that minor surgery is surgery for which it is not really necessary for the patient to be admitted into a hospital ward—*i.e.*, surgery which can be performed in the out-patient departments and in the casualty rooms.

On this definition this book seems to be well suited to the senior student on front surgery and the newly qualified houseman, though the general practitioner will find that his experience will have taught him most of the contents.

The book, as a whole, is well set out and is not too big for the pocket. It is well illustrated with line drawings of incisions and photographs of instruments. An index, always so valuable, is provided.

The chapter on fractures is profusely illustrated with X-rays of fractures and photographs of plaster technique.

The senior student should obtain much help from the chapter on bandaging and tying of knots, small details which are often so shoddily performed, and which can contribute to the comfort of the patient at so small an extra expenditure of energy.

The chapter on infections of the hand might well be expanded since these injuries form so large a proportion of the cases admitted to front surgery besides being so important industrially. The same applies to the chapter on the eye and ear, which is rather sketchy.

The operation of tonsillectomy seems out of place in minor surgery, and much of the space devoted to genito-urinary surgery and amputations seems unnecessary.

On the other hand, the chapters on anæsthetics and fractures are well written and comprehensive and will be invaluable to inexperienced house-officers. The latter will also find the notes on after-treatment very useful, particularly if the ward sister is on holiday.

Although we have criticised, mainly over the author's choice of matter for inclusion under the heading of minor surgery, we can recommend this book as a useful guide for the senior student, lacking in that assurance which goes with responsibility and the houseman overburdened with it. J. P. M. B.

Massage and Remedial Exercises. By Noel M. Tidy. Published by John Wright and Sons, Ltd., Bristol. *Price* 25*s. net.*

THE fact that this book has run to six editions in twelve years should be sufficient indication of its merit. Miss Tidy's book is the complete encyclopædia of treatment by massage and remedial exercises, and gives the pathology, the indications for treatment and the methods to be employed for every type of case, both surgical and medical. For the massage student it is the complete text-book to prepare her for her examinations, while for the qualified masseuse it is an invaluable reference book.

In these days of rehabilitation most of us are conversant with the treatment of fractures and other injuries, but remain in complete ignorance of the physical methods employed in the treatment of many medical conditions, and it is in this field that Miss Tidy's book is of definite value to the medical practitioner.

In this latest edition the chapters dealing with fractures have been rewritten and brought up to date. If one were to criticise it would be to suggest that the section dealing with sciatica is due for revision, the prolapsed intervertebral disc, the commonest cause of the condition, not being mentioned. The book as a whole is thoroughly sound and can be recommended to all those who practise or are interested in physiotherapy. E. J. C.

Dental Histology. By AITCHISON AND DICK. John Bale Medical Publications. *Price* 18*s*.

THE first half of this book deals exclusively with the preparation of dental tissues for microscopic examination. It commences with a description of the microscope itself, and proceeds comprehensively through various methods of fixing, decalcifying, sectioning and staining. There is a short interesting account of a method of taking photomicrographs with an ordinary camera, and the remainder of the book is devoted to a summary of the microscopic appearances of the dental tissues. This is written in the same crisp style as Mr. Aitchison's "Dental Anatomy for Students," which has proved such a stand-by for the L.D.S. examination. At the end of the book are twenty well-captioned photomicrographs in black and white, the clarity of which would be hard to surpass.

This is an excellent book, but it is not written for the student who regards this subject as academic, to be read for a professional examination and speedily forgotten.

J. B. K.

Correspondence

PRESIDENT'S ADVICE TO STUDENTS.

To the Editor of the GAZETTE.

SIR,—May I, through you, thank the students for making me the first President of their union. It is indeed needed in these times. May I also make a few remarks on each of its three functions. I do not think we shall have much to do in stimulating athletic activities. They have long been virile. The health of any sport in our midst depends not so much upon the prowess of the first team, as upon the number of teams turning out regularly. It is better that many teams should lose every match weekly than that one team only should turn out and beat all the famous clubs in the kingdom.

In cultural activities there is much to be done. We in London are at a disadvantage, not only with the undergraduates of the older universities of Scotland and of England, but also of those younger universities, most of which have arisen as offshoots of ours. Distances are so great that we are unable to gain that unofficial friendly contact either with students of the same faculty or, which is more important, with those of others. There is, therefore, some room for organisation in this matter; but, remember, that when cultural activities are artificially cultivated they tend to wither or to become weeds. Cultural activities can only be developed by the personal initiative and effort of each individual. Yet it is every bit as important to the doctor as his medical knowledge. I fear that as a profession we have gone down from the standard set us by the medical profession of the eighteenth century. We need to get back to that. If education has not led us out to continue some of the interests we studied at school that school has failed in its purpose and we are letting it down.

I do not mind what it is—music, literature, art, bird-watching, butterflies or gardening—but unless you have some of it you will make poor doctors, and it is a matter that rests with yourselves. Neither by examination nor by any other method can it be assessed in the decision as to whether you should be admitted to the register. It is your responsibility.

The third function of the Students' Union is that it should give you a medium whereby you can discuss and disseminate your views on matters of the day under three headings. First, to have some say in the running of the Hospital and the School. You are entitled to express your views and you are entitled to have them listened to. Once you have gained this latter your views must carry their own weight. You

cannot claim they should be accepted; you cannot know all the factors that have to be weighed in coming to a decision; and you have no responsibility. This rests with the governors, and the responsibility for advising them rests with the staff. Everyone else at Guy's is *in statu pupillari*—the junior staff to gain their experience and to pass their higher examinations, house officers to learn to take responsibility, to exercise judgment and to develop the conduct of practice; undergraduates to learn to be good doctors and to get through their final examinations. Once these objects are achieved it is time for you to go, unless you become one of those chosen few that gain admission to the staff. But remember this: the fame of Guy's depends not upon us who stay, but upon those that go out into all the world.

Then there are those matters concerned with the maintenance of health, which to-day are changing rapidly from all points of view, so that doctoring is no longer a one-man job, but is becoming the leading part in a great industry of health. You must all give thought to the future of this, for you will conduct your practice under very different conditions that exist to-day.

Then there are all those matters of a national and an international type at which we doctors can look with an independent view from our special knowledge and experience. Upon all of these you must be prepared to develop your views. The greatest of my seniors, Mr. Wilfrid Trotter, has said that at this time medicine holds a wholly unique importance for the very existence of social life. The fact that we are non-political does not mean that we must not discuss matters that are the subject of political strife; it means that we must not do so from a party standpoint nor pass resolutions in support of one party's views or another's. The fact that we are non-sectarian does not mean we may not discuss matters of a higher moment; it means we must not do so to the detriment of or in support of any of the various sects throughout the world.

With these words, then, I will close. You will see that you have much to do, much to think, and much to say outside the routine of your studies.

Yours, etc.,

T. B. LAYTON.

DENTAL TRAINING PERIOD.

To the Editor of the GAZETTE.

SIR,—In a recent number of the *Gazette* there was published a letter in which it was stated the Dental Council of this Hospital has recently extended the clinical period of study for dental students from twenty-four months to twenty-eight months.

I should like to point out that this statement is without foundation and, at the same time, to give a true statement of the change in the curriculum that may have led to such a misconception.

Until a few years ago the period of time devoted to the study of Dental Mechanics and Prosthetics as laid down by the Royal College of Surgeons was twenty-four months. This, together with twenty-four months' period of clinical study, made up the four years of professional study. A reduction in time for the study of Dental Mechanics and Prosthetics was then made by the College to a period of twenty months, but no reduction of the full four-year curriculum was made. It is obvious, therefore, that the intention of the regulations is to allow the four months subtracted from Dental Mechanics and Prosthetics to be used for the study of Prosthetics nearer the time of the Final Examination, thus still keeping the time of professional study to four years. The object of this change was to refresh the student's memory and practice in Prosthetics, a type of work which would enter largely into his professional practice at a time when he would be shortly qualifying, instead of leaving an interval of two years during which time, under the old regulations of the College, he would not have come into any contact with it.

This statement of the position has the approval of the Director of Examinations of the Royal College of Surgeons.

Yours, etc.,

F. BOCQUET BULL,
Sub-Dean of the Dental School.

Medical School,
Guy's Hospital, S.E.1.

CLUBS' UNION AND *GAZETTE*.

To the Editor of the GAZETTE.

SIR,—In the " Passim " of the *Gazette* of September 2nd, 1944, it was suggested that the Students' Union desired to control the *Gazette*. The Union wish to dissociate themselves entirely from any such suggestion and wish to emphasise that it has never been discussed by the Union or its committee.

We wish to join the Editor in expressing a desire that the *Gazette* should remain an independent organ portraying the many sides of Hospital activity and that its columns remain open to anyone connected with the Hospital.

Yours, etc.,

B. D. GRANT

(Acting Hon. Secretary, Students' Union.)

(Whilst the above suggestion to the Editor had been made privately, he was under the mistaken impression that it represented a considerable body of student opinion. He apologises for the misunderstanding and thanks the acting hon. secretary of the Students' Union for clarifying the issue.—ED. NOTE.)

Cricket Retrospect

THE Hospital cricket season was moderately successful despite the mournful shadows cast upon it, first, by the advent of D-day, and, secondly, by the attendance of the flying-bomb.

Murphy, the United Hospitals vice-captain, played a large part in the season's success, not only by his brilliant batting, typified in his undefeated century against Beckenham, but by his masterful captaincy, best shown in his handling of the bowling against the London Hospital.

Of last year's side few were left to play regularly this year ; of these few, Thompson contributed some useful innings in the middle of the season, a 45 against the R.A.A.F. being his best, and he also returned as a bowler with some effect after a two-year lapse.

Sheerboom, on the whole, batted well, in particular aiding Murphy to defeat Beckenham and his cover-point fielding deterred many an ardent bat taking that quick single, while Saunders, impeccable in the field as always, took strong wickets against the Metropolitan Police and Woolwich, but his appearances were, alas, only too infrequent.

Trist, as a newcomer to the side, distinguished himself in too many matches to mention, his thirty-eight wickets for just over nine runs apiece speaking for itself ; his first overs, fast off the pitch, breaking sharply, wrought havoc in many sides' opening batsmen.

Of the other newcomers it was Graham who, perhaps, came nearest to challenging the genius of Murphy as an all-rounder. He always batted aggressively and the subtlety of his bowling lay in the difficulty of determining whether the ball was going to deliver him or he the ball. Graham, shaggy of head, unorthodox in stroke, will be a great asset to the side for several seasons to come.

Williams, a young opening bat, and Webb, a useful change bowler, also contributed good performances. Williams, correct in stroke, pleasing in style, will improve directly as his strength, but I doubt if Webb's strength has anything to do with his excellent bowling.

Those members of the side jealous of the ability and prowess of Carton-Kelly suggested that he should be wholly employed in his secretarial duties—even on Saturday afternoons !

In conclusion, we extend thanks to Kirby, in his untiring efforts to make the ground ready for the winter and to " Alf " we wish a speedy recovery and a rapid return to his duties on the ground.

L. D. C.-K.

Sport

Cricket

GUY'S *v.* METROPOLITAN POLICE.

Result: Lost. Scores: Metropolitan Police, 123 for seven; Guy's, 14.

Guy's won the toss, put the Police in to bat, and soon had them in difficulties. Trist, with brisk twists of the wrist, dismissed three early batsmen very cheaply, but the Police, however, recovered and were able to declare at 123 for seven.

Despite the old Latin tag, "*De mortuis nil nisi bonum*," I feel bound to say a few words about the moribund efforts of the Guy's batsmen. Our players were nothing if not consistent—two 5's and five 0's being mainly responsible for raising the total mentioned above. This alfresco fiasco started when Murphy, apparently bent on running himself out, hit the ball straight to a fielder and immediately set out for the opposite end, but on receiving no encouragement from Thompson, who was dug well in and leaning on his bat in the best style of the British workman, returned to his wicket to find the bails missing. Cricketer followed cricketer and the score soon read 14 for five, but the last five men, each, needless to say, obtaining similar scores, were unable to add to the score so much as one jot—nay, even one tittle.

Team.—E. G. Murphy, L. D. Carton-Kelly, D. R. S. Saunders, G. Thompson, D. J. Sheerboom, A. E. Trist, K. G. B. Pritchard, E. W. Graham, J. D. Williams, W. B. Webb.

GUY'S HOSPITAL *v.* LONDON HOSPITAL.

Result: Guy's, 78; London, 50.

Guy's, somewhat cowed by their efforts of the previous week, were now faced with the formidable task of defeating the London Hospital, only twice beaten throughout the season. The Hospital fared badly at the start, and it was left to Clarke, who first presented mid-off with a simple catch, which he, fortunately, dropped, to improve the situation. Graham and Saunders carried on this good work, but in spite of their efforts, the final total was only a modest 78, Shaddick being mainly responsible for dismissing us so cheaply. Trist immediately set about the London Hospital batsmen and, aided by two excellent catches by Saunders and Murphy, who has captained the side with great skill throughout the season, soon had the scoreboard reading four for 3.

Wray and Shaddick slowly raised the London Hospital score, but Clarke, in his second spell, and Webb, coming on as a change bowler, soon put an end to this and, between them, dismissed the rest of the side for a total of 50.

Team.—E. G. Murphy, C. B. Clarke, L. D. Carton-Kelly, D. R. S. Saunders, G. Thompson, D. J. Sheerboom, A. E. Trist, E. W. Graham, W. B. Webb, J. D. Williams, R. J. Finney.

Guy's Hospital Boxing Club

A general meeting of the Guy's Hospital Boxing Club will be held in the Anatomical Theatre on Wednesday, October 4th, at 1.15 p.m.

A general meeting of the United Hospitals Boxing Club will be held in the Medical School Committee Room on Friday, October 13th, at 5.15 p.m.

All Students interested in boxing are invited to attend.

Hospital Information, etc.

Notice

The Harvest Festival in Guy's Hospital Chapel will be held on Sunday, October 15th, 1944. The preacher at the 10.45 a.m. service will be the Rev. C. L. B. Bishop, Warden of Trinity College (Cambridge) Mission, Camberwell, and in the evening at 9.15 p.m., the Provost of Southwark Cathedral.

Roll of Honour

The following names have been lately added to the Roll of Honour of London University:—

Staff.

Captain J. B. C. Murdoch, R.A.M.C.

Graduates.

Surg.-Commander A. E. P. Cheeseman, R.N.
Surg.-Commander A. W. Cocking, R.N.
Surg.-Lieut. M. C. Cross, R.N.V.R.
Surg. Lieut.-Commander C. H. Egan, R.N.
Lieut.-Col. C. C. G. Gibson, R.A.M.C.
Surg.-Lieut. R. L. Greenfield, R.N.
Major H. M. R. Knight, R.A.M.C.
Captain A. E. Locke, R.A.M.C.
Colonel D. Lurie, S. African M.F.
Surg.-Lieut. Commander Leslie Merrill, R.N.
Captain E. J. A. Needham, R.A.M.C.
Flight-Lieut. W. S. Pitt-Payne, R.A.F.V.R.
Flg.-Officer J. W. Robb, R.A.F.V.R.
Surg.-Lieut. E. R. Roseveare, R.N.V.R.
Dr. Robert South, Merchant Navy.
Captain W. F. J. Weston, R.A.M.C.

Change of Address

D. G. Dixon, Capt., R.A.M.C., 179 Field Ambulance, B.L.A.

Roy Evans, Lieut.-Col., R.A.M.C., 34 Casualty Clearing Station, B.L.A.

P. Fourman, Lieut., R.A.M.C. (317822), Combined Military Hospital, India.

I. S. MacLeod, Captain, R.A.M.C. (287239), 6th W.A. Field Ambulance, S.E. Asia Command.

G. W. Nicholson, M.D., Orcombe, Histon Road, Cambridge.

G. F. Swann, Surg.-Lieut., R.N., H.M.S. "Fal," c/o G.P.O., London.

G. V. L. Williams, Lieut-Col., A.D. Corps (87714), A.D.D.S., H.Q., No. 1 District, C.M.F.

Papers by Guy's Men

Harvey, Warren and Others. The Acidity of Dental Cements. *Brit. Dent. J.*, 1944, **77**, 89.

Havard, R. E., and Another. Dangers of Internal Alkali Treatment in Blackwater Fever. *Lancet*, 1944, ii, 338.

Awards

M.B.E. (Civil).

A. C. Taylor, M.R.C.S., L.R.C.P.

Births

FORBES.—On May 19th, 1944, at Johannesburg, to Dorothy, wife of Captain Arthur Forbes, S.A.M.C.,—a second son, John Maxwell.

EDS. {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

IN our last issue we bade welcome to those newly arrived at the Hospital, be their studies medical, dental or nursing. We hope that by this time they have been able to find their way round the Hospital. It must, indeed, gladden the ears of the Medical School staff to hear the empty rooms re-echo once again to pre-medical activities. (Empty and hungry stomachs still resound tympanitically, so crowded is the "Spit" these days !)

Some of our teachers gave good advice to our new entrants in the last issue, but scant mention was made of that indefinable entity, Guy's tradition. Now, this Hospital before the War, placed a high premium on the value of its traditions. During the War this has been somewhat in abeyance. The real point at issue is—firstly, are these traditions worth retaining, and, secondly, should they take the same form ?

To deal with our first point. Tradition in a centre of learning is, *a priori*, an essential element in the teaching, no matter what the subject is, for what is knowledge if it is not an accumulation of opinion and belief, truly tried and tested, which is handed down from teacher to student. Thus did our forefathers learn.

Tradition in learning takes on a further fresh importance at the present time, for so great is the extent of our knowledge and so potentially destructive is it, that advancement of learning must proceed circumspectly and with caution lest we be caught in our own noose. Tradition *rightly* used will help to avoid that unfortunate end. We say "*rightly*," for tradition, like every other virtue, can be, and is, readily abused. When we do not recognise the time and season in which to prune our vine that it prosper, then is tradition mocked.

And now, can these traditions be the same after the War when life at Guy's flourishes again ? If the Goodenough report comes to pass, these traditions will take quite a different form since the type of student entering will be different ; emphasis on points of teaching will be altered ; and, above all, the attitude of the whole world to some of its own traditions will be quite new. Therefore, we feel that there is a grave danger that the ideas of tradition will sink beneath the storms of orientation which will surely rage in our post-war world.

To sum up, then, we have tried to show how important is the idea of tradition in our teaching and learning, and that there is, in addition, a grave danger that this idea may be easily lost. Therefore, we humbly beg the present generation of students (including ourselves) and those who follow, to realise, before it is too late, the value of something which they are in danger of losing.

MANY students have been concerned recently about the appointment of house-officers in the sector. At a recent meeting at Guy's, Professor Johnston pointed out to a meeting of students that newly-qualified men ought to feel some measure of loyalty to the sector and apply for appointments in it rather than elsewhere where jobs may, perhaps, be more lucrative but have not the advantage of the visiting honorary staff of their own teaching hospital and the continuity of teaching thereby resulting. Mention was also made of the increased number of beds being made available now.

Furthermore, it was suggested to Professor Johnston by those present that the selection of house-officers might be more carefully made, that no post should be held for longer than six months and that men should be moved round the sector more frequently.

IT is now a month since we published the proposed plans of the new Hospital and not one letter have we received expressing approval or disapproval. Surely our readers are not so apathetic that such a magnificent project cannot wrest from them some slight murmur of interest ?

The Ophthalmic Casualty

By FRANK W. LAW, M.D., F.R.C.S.

Extracts from a Clinical Lecture delivered at Guy's Hospital Medical School on Monday, July 24th, 1944.

I APOLOGISE for the rather hackneyed title of this lecture. It is not laziness which has dictated it, nor is it excessive business—though we are all rather busy nowadays—but the subject does seem to be very much on the carpet just now, and I hope that will justify the delivery of this lecture.

Let us define what we are going to talk about. We know what a casualty is, but I would like to consider casualties to-day under the headings of general and special, and to discuss traumatic emergencies and injuries of all kinds. That will eliminate many non-traumatic emergencies brought to the surgery or to out-patients', such as occlusion of the central retinal vein or artery, detachment of the retina, macular hæmorrhage, vitreous hæmorrhage, and so on. These for the present purpose we will omit. We will consider traumatic emergencies under the heading of "general," such as might occur at any time, and special, such as the cases with which we are dealing particularly to-day—namely, the air-raid casualties. We will not include battle casualties, because for the most part battle casualties come very much later into our care, and more often than not have received at least first-aid treatment, if not very much more, by the time they come into our hands in this country.

Under the heading of "general" let us consider the simpler injuries of the eye. An eye which has been bruised, or brushed by some foreign material, may be irritable, sore and red, but no further injury may be found on examination. The condition may be called "traumatic hyperæmia." The treatment is symptomatic, and the outcome almost invariably good, though it may be difficult to impress that on the patient, who feels possibly more discomfort than a patient suffering from a perforating injury of the globe. The eye must be put at rest and a drop of oil instilled; then, provided you are quite satisfied yourself, you will be able to inspire a little confidence in the patient, and all will be well.

The next stage of injury one might consider is one that has gone past that stage and shows itself as a corneal abrasion. I need not give you a detailed list of possible causes of corneal abrasion. A common one is the finger-nail, particularly the baby's finger-nail, and sometimes the resulting condition is very difficult to heal. But the number of conditions which may cause an abrasion is, of course, legion and needs no detailing.

Before we go any further let me get off my chest my old plea for the use of fluorescin, for without it no definite statement may be made about the state of an injured eye. I cannot think of any condition of the eye, however severe, in which fluorescin is not permissible. Put in a drop of 2 per cent. fluorescin, wash out the excess, and deposit what there is to be deposited, with a drop of boracic lotion, and any abrasion or injury will be demonstrated to you by a green stain. It is as simple as that. How the general practitioner can live without fluorescin—or perhaps I had better say, how his ophthalmic patients can get along without fluorescin—I do not know.

An abrasion or laceration of the conjunctiva is equally well demonstrated by fluorescin, but this is rarely necessary, for a laceration of the loose covering membrane as opposed to a firm skeletal transparent structure, such as the cornea, is very much more easily seen. If you will forgive my being very elementary, may I remind you to differentiate very clearly between the "white of the eye" in so far as it is conjunctival or scleral. Which is it? What is the anatomy of the conjunctiva? It covers the sclera from the limbus for a varying distance, and is then reflected forwards on to the posterior surface of the lids. Above and below, there is a well-marked conjunctival fornix; laterally it is very shallow and medially it is absent. One may find considerable laceration of the overlying mucous membrane, the conjunctiva, without damage to the sclera. The point is to have the anatomy of the parts quite clearly in one's mind.

The subject of the foreign body must be touched upon as we are dealing with minor injuries of the eye. A foreign body of almost any nature may be in almost any situation on the eye. If on the surface of the conjunctiva it is easily seen and easily removed, unless embedded. If on the cornea it is often easily seen, but it may be very small, and you cannot trust the unaided eye not to miss a very small foreign body. Therefore,

the condensing lens and the examining loop are still essential. Never let the patient go away in doubt without instilling fluorescin, which will settle to some extent around the foreign body.

A very favourite place for a foreign body is the sub-tarsal sulcus, situated one-third of the way up the conjunctival surface of the upper lid. A grain of coal-dust will not be missed, but such a body as a small husk of grain may be missed because it does not show up on the conjunctival surface. A favourite place is down in the lower fornix, and that is often discovered by the victim on everting the lower lid.

With the embedded corneal foreign body one is taught to start with a small pledget of wool on a stick soaked in cocaine, and then the dry wooden applicator, without any wool; then the spud and, last, if still failing, one is allowed to use a Bowman's or Saunders's needle. Personally I prefer to attack a foreign body straight away with a Bowman's needle. I deprecate the use of the spud, which is bound to injure the cornea if used for any other purpose than merely lifting a foreign body off the cornea.

Taking the more severe general injuries of the eye, one passes from abrasion to perforation and from the foreign body on the surface to the intra-ocular foreign body. The classical intra-ocular foreign body shows a perforating corneal wound, a hole in the iris, a traumatic cataract (possibly localised), and nothing more is to be said about it as regards diagnosis. But the more difficult one is that which has entered, let us say, at or near the limbus. The conjunctival injury may be quite invisible. If the foreign body missed the iris there is no hole in the iris. If it missed the lens, there is no cataract. For some reason or other, it may be vitreous haze, or hæmorrhage, or perhaps just incompetence, one cannot find it on ophthalmoscopic examination, but there it is and, if left and if metallic, there may be a train of visually destructive results which must if possible be avoided.

The procedure of dealing with the intra-ocular foreign body is extremely interesting, highly complicated and specialised, but our difficulties are enormously increased in view of the fact that so much of the explosive containers used in modern war are made of non-magnetic steel. Entering an eye for the removal of a non-magnetic foreign body has many hazards, and I think I should say that on the whole it is unlikely to repay one. The removal of a magnetic intra-ocular foreign body is by comparison a matter of relative simplicity.

If a perforating injury is recent it is unlikely that any kind of sealing of the wound will have occurred, and therefore the eye will probably be soft. If it is a corneal perforating wound it is evident that the anterior chamber will have been lost—that is to say, the aqueous will have escaped, and very rarely does such an event occur without incarceration if not actual prolapse of the iris. The iris, by the way, will be found to be a soggy, flabby, uncompromising piece of tissue when robbed of the support of the intraocular tension. Such prolapse or incarceration, I need not remind you, cannot occur without distortion of the pupil. Therefore, eliminating the cases where the wound is obvious, the prolapse is obvious, and possibly the lens is rendered opaque, one is aided in one's diagnosis by noting—(1) the injury itself, as to whether it looks like perforation; (2) the anterior chamber, as to whether it is of normal depth, (3) the pupil, as to whether it is distorted, and (4) the iris, as to whether it is hanging out of, or strung up to, the wound.

Perhaps rather selfishly, I do press that you should have a clear mental picture of an injury to the eye before ringing up the man whose job it is to know perhaps a little more about it than other people. In your opinion it may be an emergency. If you tell him, your responsibility ends. He may not come at once for various reasons, but you have told him, and as long as you have told him enough to enable him to say in his own mind what is wrong with the eye, you have done your job. But it is very difficult for the surgeon, especially if he is many miles from the hospital, when he receives a haphazard description.

The principle of treatment in perforating wound with prolapse is to cut away any prolapsed tissue, and to put the eye in the best possible condition for healing, usually putting the wound under a flap of conjunctiva, which, sutured across the cornea, retracts in about a week, by which time the corneal wound has healed. Trauma of the more severe kind may cause such complications as hæmorrhage into the anterior chamber, known as hyphæma, hæmorrhage into the posterior chamber, which cannot be seen, and hæmorrhage into the vitreous, which can be seen with the ophthalmoscope, or possibly merely deduced from the ophthalmoscopic appearance behind the lens. There may result that rather odd condition called commotio retinæ. The pathology

of this is probably a traumatic œdema with coagulation necrosis of the retina, often accompanied by hæmorrhage. If you see an eye that has been injured beyond doubt, though not perforated, and the man says he cannot see, or that his sight is not what he would like it to be, do not just have a look at the anterior segment and possibly feel the tension, find all is well and reassure him ; he may have commotio retinæ, and visual recovery varies considerably. Commonly the macula suffers most, the retina being a highly specialised tissue, and the macula the most highly specialised portion of it, so that it would appear biologically to be the more vulnerable. Although there may be little to see ophthalmoscopically two months after the accident, the injury and the damage which the retina has sustained may result in very severe diminution of visual acuity.

A word upon the condemnation of an injured eye. It is a very difficult matter to decide whether an eye which has just sustained, let us say, a perforating injury is or is not hopeless. There are few—very few—which leave no question as to the fact that they are finished, but there are many others where a very reasonable doubt may be said to exist. Although I have been at this work for many years now I do assure you that I frequently have great difficulty in deciding that an eye is hopeless.

About a fortnight ago I was called to some air-raid casualties in a suburban hospital, The case I am thinking of was that of a middle-aged woman whose ocular condition was summed up in the rather trite phrase, "Both eyes disorganised." Her face was certainly disorganised ; it was difficult to see where things began or ended. There were multiple small traumata, though no very deep gashes. But when I had defined where her lids were, and had got some of the debris away, and had removed some of the coagulum which was holding them together—this was twenty-four hours after the injury—I found, to everybody's delight, two practically normal eyes. The diagnosis "Both eyes disorganised" must have been made because there were red masses where the eyes ought to have been, but those happened to be the lids.

Therefore I must impress on you the difficulty of determining that an eye is hopeless. Let me put it in this way. Supposing you have an eye which has been cut across by a piece of glass, the iris hanging out and the lens injured, and that the man had lost the sight of the other eye before, there are very few people who would take that eye away. They would leave it alone, for one never knows. There was a boy in Brook Hospital in the early days of the explosive incendiary. He and his pal both had injuries to both eyes which were indistinguishably severe. The one boy has lost both eyes. The other came to my out-patients' a fortnight ago ; he has a staphyloma (a bulging of the thinned cornea), but elsewhere a nice clear cornea and the lens is clear. The story, unfortunately, does not end where it should for the purposes of illustration, because the injury at the moment of reception had caused such commotio changes in the retina that he had macular changes, organised exudate, and pigment migration in the macular zone. Nevertheless, he will be able to see 6/24 for the rest of his life ; without his retinal damage I have no doubt he would see 6/6. Yet between the eyes of those two boys there was little difference on examination soon after the injuries.

The difficulty arises because the injured eye may be a danger to the fellow eye. A plastic iridocyclitis, possibly resulting from an allergic sensitivity to uveal pigment, may start in the fellow eye as a result of a perforating injury. Such inflammation in the second eye, known as sympathetic ophthalmia, may occur at any time between two weeks and twenty-five years after the injury, according to the published reports. Sympathetic ophthalmia is said never to occur in the second eye after removal of the first, though I think there are very rare exceptions to this statement. Once it is established—once the second eye has become involved—the removal of the exciting eye has little or no effect on the course of the disease. Therefore, if you are too late, it may even be well to leave the exciting eye, for the inflammation in that eye may be of a less severe degree than in the sympathising eye, and if you leave both eyes in you may find that the originally injured eye is the better in the end.

That, then, is the reason why one is concerned about the condemnation of an injured eye. All worry ceases if the injured eye is removed within a fortnight. On the other hand, one cannot treat all perforating injuries of the eye by the simple manœuvre of removal.

In connection with air-raid casualties, other injuries which the victim has sustained are frequently of a complicating nature. There may be injuries to the lids and to the face, and great swelling of the lids. The general condition of the patient as regards surgical shock has also to be considered. It is very rare that one cannot examine an injured eye, at any rate in anybody of reasonable age, but I warn you against any

kind of clumsy manipulation for the reason that you may further damage an already injured eye. If the patient does not want you to see his eye you will not be able to see it, but it is wonderful what one can do by the exercise of a little gentle persuasion. Do not shout at the patient; always talk quietly, and try to get him into the role of a passive collaborator. For example, if one asks the patient to do the best he can to look down and *let the eyelids open* it is far more likely to produce the desired result than peremptorily to tell the patient to open his eye. The patient is much more able, if I may express it so, to let his eye open than to open it—possibly the "cussedness" of human nature comes in. The separation of the lids, of course, can very often be brought about by gentle traction by the finger and thumb, without pressure, on the globe; but you will very often get a better view with less manipulation if you use retractors. Instil a drop of cocaine if it is going to help the patient and save him from suffering pain, and then insert very carefully the silver wire retractors. Gentle retraction of the lids will be easily achieved.

Air-raid casualties often have to undergo operations other than ophthalmic ones, even if it is only the putting in of a suture, and these occasions may provide the opportunity for carrying out the eye operation, only one anæsthetic being necessary instead of two. In other cases it may be justifiable to wait, for the patient may be in a better condition, having recovered after the first shock of his experience, and there is nothing to lose by a delay of twenty-four hours in the case of most eye injuries. A prolapse of the iris does not harm by waiting for a few hours. I am not going to say that the chance of sympathetic ophthalmia is unaffected by the length of time the iris is protruding from the eye, but I recommend that you put the onus on the man who is going to treat the case by letting him know of the condition as early and as accurately as you can.

Finally, three "do's" and three "don'ts":—

(1) Always exercise the utmost care in manipulation of the lids and face in the case of suspected eye injury.

(2) Never examine a patient (other than a baby) without his co-operation and help or, at any rate, take steps to achieve that co-operation before trying to force the lids apart.

(3) *Always have a drop of fluorescin by your side to decide whether there is a* surface lesion.

(1) Do not feel the tension of an eye which you suspect of a perforating injury, for if your suspicion is correct you may further damage it by pressing out the intraocular contents.

(2) Do not worry over prolonged examination of the eye if the patient is shocked or otherwise injured, but wait until the general condition has improved. On the other hand, if an anæsthetic is to be given for the purpose of general surgery, inform the ophthalmic surgeon of any eye injury, if possible, before this is done, for the one anæsthetic may then serve both purposes.

(3) *Do not ring up for help unless you have a good mental picture of the injury* you are going to describe. One does not want technical terms or exact diagnosis, but it does help very much if you tell the surgeon, for instance, that the iris seems to be tied up against the cornea. In that way you are passing on valuable information.

The Musical Society

ENQUIRIES have been received about the activities of the Guy's Hospital Musical Society. At the last committee held in 1939 it was decided to suspend all official activities for the duration. This was principally in order to keep the society in a solvent state and out of respect for those of its members who through service abroad or through the Sector system, would be unable to share or have a voice in its activities. In the meantime, however, music has been enjoyed and performed by groups in many parts of the Sector, not to mention Guy's itself, and it is suggested that similar activities might be arranged this term in Guy's. No financial assistance or organisation is intended, but anyone interested in madrigals, other part singing, solo or collected instrumental playing is invited to send suggestions or enquiries to the Hon. General Secretary, E. W. Baxter, Biology Department, Medical School, Guy's Hospital, S.E.1, or to J. E. Blundell, The Hostel, Guy's Hospital.

NOTE.—There is a gramophone at the disposal of the Society, but it is not available just now.

E. W. B.
J. E. B.

Correspondence

ANTIENT SOCIETY OF COGERS.

To the Editor of the GAZETTE.

SIR,—The statement in your issue of September 30th that the *Gazette's* columns are open to anyone connected with the Hospital and your appeal for new contributors encourages me, a humble employee of the Hospital, to send this letter. Mr. Layton, in the same issue, stressed the importance of cultural activities and urged a return to eighteenth century standards, and it therefore occurred to me that some of your readers might be interested in a society which survives from the eighteenth century and exists for the discussion of literary and political subjects amongst others, and also gives an opportunity to cultivate the art of public speaking.

The Antient Society of Cogers, founded in 1755, is the oldest debating society in London and continues to meet every Saturday night for discussion of the events of the week. The debate takes an unusual form, as there is no fixed motion, but the opener is allowed forty minutes to review the events of the week, the first speaker in the discussion fifteen minutes, and subsequent speakers ten minutes. The society was founded by Daniel Mason, of whom little is known except that he was a tallowchandler, and the name is derived from the phrase which was the basis of Descartes' philosophy—"*Cogito ergo sum.*"

John Wilkes was president or "Grand" in 1756, and we like to think that Dr. Johnson attended, although there is, alas, no mention of him in the records. Charles Dickens almost certainly was a "Coger," and is said to have based some of his characters on members. Who knows but that the best known Guy's man of all, Bob Sawyer, that "cutter and carver of live people's bodies" as Mrs. Raddle called him, was not originally a "Coger"? One thing is certain and that is the need in these days of totalitarianism and regimentation of a society with the objects of the "Cogers," which are—"the promotion of the Liberty of the Subject and the Freedom of the Press; the maintenance of Loyalty to the Laws, the rights and claims of Humanity, and the practice of public and private virtue."

We meet every Saturday at 6.30 p.m. at the "Peacock," Maiden Lane, Charing Cross, and extend an invitation to any men from Guy's who care to come and spend a pleasant evening. There is a ladies' night on the first Saturday in every month, and on October 14th Richard O'Sullivan, K.C., will be the opener.

Yours, etc.,

Front Lodge, Guy's Hospital, S.E.1. S. J. BACON.

Entry of Students, October, 1944

MEDICAL

PRE-CLINICAL.

Name.	*Year.*	*School or College.*
Bailey, M. F. A.	1st	Stonyhurst College.
Barrett, P. K. M.	2nd	Cardiff High School.
Bass, B.	1st	Cardiff Technical College.
Boulter, P. S.	1st	Carlisle Grammar School.
Bowen, H. G.	1st	Aberdare County School.
Breese, J. E.	2nd	Harrow School.
Brice, J. G.	2nd	Gravesend County School.
Brown, R. M.	2nd	Worthing High School.
Copeland, B. I.	1st	Wanstead County School.
Deacon, D. F. C.	1st	Hymer's College, Hull.
Deacon, G. R. C.	1st	Hymer's College, Hull.
Ellis, F. G.	2nd	Royal Grammar School, Worcester.
Evans, I. E.	2nd	Neath County School.
Evans, J. H.	2nd	Cranleigh School.
Filose, G. N.	1st	John Fisher School, Purley.
Francis, H. W. S.	1st	Queen Mary's Grammar School, Walsall.
Galbraith, N. S.	1st	Tonbridge School.
Garland, W. H.	2nd	Wellingborough School.
Garner, R. G.	1st	Ackworth School, Pontefract.
Gillison, N. B.	1st	Bedales School, Petersfield.
Hartley, B.	2nd	Farnborough Grammar School.
Holden, J. M.	1st	The King's School, Macclesfield.
Hurwood, H. A.	2nd	Denstone College.
Jones, E. T. J.	1st	Tregaron County School.
Jones, J. A. B.	2nd	Lewis' School, Pengam.
Kaner, P. G.	1st	John Bright County School, Llandudno.

Name.	*Year.*	*School and College.*
Kellaway, T. D.	1st	Helston County School.
Kreeger, L. C.	2nd	Willesden County School.
Laird, J. C. M.	1st	Trinity College, Glenalmond.
Lennie, D.	1st	Berkhamsted School.
Lewis, M.	1st	Highbury County School.
Lommerse, P. G. W. A.	2nd	The King's School, Peterborough.
Lynn, C. R.	2nd	Owen's School, Islington.
McKendrick, W. H.	1st	Epsom College.
Maine, I. H.	1st	Bedford School.
Mason, A. A.	2nd	Raine's Foundation Secondary School.
May, D. G.	2nd	Surbiton County School.
Medlock, J. M.	1st	Haileybury College.
Morris, J. D.	2nd	Denstone College.
Moss, I. S.	2nd	Trinity County School, Wood Green.
Newton, E. M.	1st	Hanley Castle Grammar School.
Nicholson, R. G.	2nd	Epsom College.
Owen, P. E.	1st	County School, Pontypridd.
Perks, B. P. W.	1st	*Whitgift School.*
Rocker, I.	1st	Hendon County School.
Rogers, J. L.	1st	Penzance County School.
Romans, D. H. M.	1st	Queen's College, Taunton.
Rowland, T. I.	1st	Shrewsbury School.
St. John, H. N.	1st	Harrison College, Barbados.
Salmon, A. J.	2nd	Bradfield College.
Sowerby, P. R.	1st	Keswick School.
Taylor, B.	2nd	Letchworth Grammar School.
Thomas, I. B.	1st	*County School Pontypridd.*
Vaughan, C. B.	1st	Harrison College, Barbados.
Walker, F. H.	1st	Arnold School, Blackpool.
Whitaker, B. L.	2nd	Woking County School.
Williams, G. R.	1st	Tregaron County School and U.C., Aberystwyth.
Williams, J. L.	2nd	Brynmawr County School.
Wyman, R. H. H.	1st	St. Edward's School, Oxford.

CLINICAL PERIOD.

Barker, W. H.	4th	Oundle Sch. & Magdalene Coll., Cambridge
Bright, P. H.	4th	Wycliffe Coll. & St. John's Coll., Cambridge
Bojé, A. C.	4th	Univ. of Pretoria.
Bowen, M. D. M.	4th	*Ellesmere Coll.* & Queen's Coll., Cambridge
Caller, M.	4th	Newcastle-on-Tyne Grammar Sch. & Emmanuel Coll., Cambridge.
Crick, A. F.	4th	Marlborough Coll. & St. John's Coll., Cambridge.
Davys, M. G. D.	4th	Marlborough Coll. & St. Edmund Hall, Oxford.
Higgins, P. J.	4th	Bloxham Sch. & Jesus Coll., Cambridge.
Inskip, John Howard	4th	Bedford Sch. & Queen's Coll., Cambridge
McEvedy, B. V.	4th	Rugby Sch. & Exeter Coll., Oxford.
Merrill, A. R.	4th	Queen Elizabeth Grammar Sch., Blackburn, and Gonville & Caius Coll., Cambs.
Potgeiter, P. J.	4th	Univ. of Pretoria.
Rees, W. J. G.	4th	*Newport High Sch. & Univ. Coll., Cardiff.*
Scott, J. D.	4th	Leighton Park Sch., Reading, & St. John's Coll., Cambridge.
Shortt, E. P. H.	4th	Oundle Sch. & Trinity Hall, Cambridge.
Sugden, D. B.	4th	Batley Grammar Sch. & St. John's Coll., Cambridge.
Turk, D. C.	4th	Winchester Coll. & Balliol Coll., Oxford.
Warrick, G. H.	4th	Monkton Combe Sch. & Queen's Coll., Cambridge.
Worssam, A. R. H.	4th	Winchester Coll. & Caius Coll., Cambridge.

DENTAL.

Attenborough, P. J.	1st L.D.S.	Worksop College.
Bailey, W. J.	2nd *B.D.S.*	*Colfe's Grammar School.*
Bowes, C. B.	1st B.D.S.	Dulwich College.
Brown, W. A. B.	1st B.D.S.	St. George's College, Weybridge.
Busfield, E. B.	1st L.D.S.	*Ellesmere College*, Shropshire.
Carson, R. M.	2nd B.D.S.	Merchant Taylors' School.
Deutsch, E. J.	1st L.D.S.	Private tuition.
Dobson, W. F.	1st B.D.S.	St. Olave's Grammar School.
Epstein, S. S.	2nd B.D.S.	Letchworth Grammar School.
Ernest, C. V. T.	1st B.D.S.	Nottingham High School.
Finkel, W.	2nd B.D.S.	Hackney Downs Secondary School.
Foster, T. R.	1st L.D.S.	Whitgift.
Freiberger, V. H.	Pre-Med.	Central Foundation School.
Gill, S. P.	1st B.D.S.	Wycliffe College.
Glazebrook, P.	1st B.D.S.	*Reading School.*
Glickman, N. D.	Pre-Med.	High Wycombe Royal Grammar School.
Gray, B. M.	1st L.D.S.	Bishop's Stortford College.
Grisewood, P. G.	Pre-Med.	*Beaumont College.*
Giulianotti, A.	1st B.D.S.	Pitman's College.
Hill, B. A.	Pre-Med.	Ratcliffe College, Leicester.
Lawrence, P. J. A.	1st B.D.S.	St. Joseph's College, Norwood.

Name.	Year.	School or College.
Marx, R.	.. 1st B.D.S.	Merchant Taylors' School.
Moore, G. E. ..	.. Pre-Med.	Eltham College.
Morgan, E. D. ..	.. Pre-Med.	Tregaron County School.
Morgan, S.	.. 1st B.D.S.	St. Joseph's Academy, Blackheath.
Morris, P. B. ..	.. 2nd B.D.S.	Leatherhead School.
Ohlrich, H. A. H.	.. 1st B.D.S.	Kingswood School, Bath.
Payne, J. A. ..	.. 1st B.D.S.	Wrekin College.
Powell, S. R. W. ..	.. 1st B.D.S.	Lincoln School.
Rees, L. A. ..	.. 1st B.D.S.	St. Albans County School.
Robinson, A. A. ..	.. 2nd B.D.S.	Tiffin Boys' School, Kingston.
Selley, W.G. ..	.. 1st L.D.S.	Exeter School.
Simmons, R. E. ..	.. 1st L.D.S.	Hurstpierpoint College.
Smallcombe, M. J.	.. Pre-Med.	Tiffin Boys' School, Kingston.
Stone, R. B. ..	.. Pre-Med.	Harrow School.
Wood, N. J. ..	.. 1st B.D.S.	Bloxham School.
Woodroof, P. J. F.	.. 1st L.D.S.	Whitgift School.
Woolf, M.	.. 1st B.D.S.	West Ham Secondary School.

Hospital Information, etc.

Notices

DENTAL SOCIETY ANNUAL DANCE.

The Guy's Hospital Dental Society Annual Dance will be held at Grosvenor House, Park Lane, on Friday, November 10th, 1944, from 8 p.m.—1 a.m. The cost of tickets is 12*s.* 6*d.* each.

In view of war conditions the wearing of evening dress will not be essential, but will be left to the discretion of the individual.

Easing of circumstances has allowed for refreshments, which will be included in the cost of the tickets. A Bar *is* available.

It will be appreciated that the organisation of such a dance presents many difficulties at the present time, and numbers have to be limited; therefore those wishing to be present should apply as soon as possible.

All members of the Hospital will be welcome.

I. D. L. THOMSON,
J. E. ATTALE,
Hon. Dance Secs.

A CORRECTION.

In our last issue the name of Surg.-Lieut. M. C. Cross appears in the Roll of Honour of London University as one of its graduates. His brother asks us to state that he graduated from the University of Cambridge.

Pass List

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
PRE-MEDICAL EXAMINATION.
September, 1944.

Chemistry.

A. A. Bailey — G. P. J. Williams

Physics.

D. J. W. Foster — R. D. F. Thiel
G. Holding

Elementary Biology.

D. J. W. Foster — R. D. F. Thiel
G. Holding

L.D.S.
1ST PROFESSIONAL EXAMINATION.
September, 1944.

Dental Metallurgy.

H. L. Lefcovitch — C. B. Palmer
J. W. McLean — F. M. Scherbel
I. A. Nelson

Dental Mechanics.

A. A. W. Fooks — A. Shotts
L. Freiberger — J. R. Timms
G. A. Kerr — J. R. Wallis
H. Prynne — C. W. H. Williams

Anatomy and Physiology.

I. L. Busbridge — F. E. N. Preston
R. E. Fever

Special Anatomy and Physiology.

J. F. Bowes — R. K. Foster
M. E. P. Easton — R. G. Iliffe

CONJOINT BOARD.
FIRST EXAMINATION.
September, 1944.

Anatomy.

J. L. Hardman — E. Killey
R. A. Keble-Elliott — R. L. Timms
E. T. King

Physiology.

N. Davis — R. A. Keble-Elliott
H. D. A. Hope — P. R. Wagner

Pharmacology.

A. G. Atkinson — T. N. Reynolds
J. A. Blackmore — R. G. Watson
J. R. Dickson

Prize Examinations, etc.

The following awards have been made:—

Treasurer's Medal and Prize in Clinical Surgery.

L. W. Godfrey .. Medal and Prize.
P. R. A. May .. Certificate.

Treasurer's Medal and Prize in Clinical Medicine.

I. S. Hodgson-Jones — Medal and Prize.
A. Batty-Shaw .. Certificate.

Golding Bird Medal and Prize in Obstetrics and Gynæcology.

J. Mervyn Thomas — Medal and Prize.

Golding Bird Medal and Prize in Bacteriology.

D. P. Nicholson .. Medal.
A. A. Cashmore, D. P. Nicholson — Prize divided.
P. F. J. New, E. A. Wright — Certificates.

Leonard Lubbock Prize in Clinical Pathology

D. P. Nicholson, E. A. Wright — Certificates.

DENTAL SCHOOL

Final Year Prize.

P. T. Parr .. .. Prize.

Prize in General Subjects.

H. S. M. Crabb .. Prize.

David Frank Sturdee Prize in Dental Prosthetics.

P. G. Shingler .. Prize.
A. Rooms .. .. Certificate.

Births

HUMPHREY.—On September 21st, 1944, at Halifax, to Irene (née Bootham), S.R.N., wife of Dr. E. A. Humphrey, Royal Halifax Infirmary—a son (Edward Guy).

KILPATRICK.—On September 8th, at Seabourne Nursing Home, Southbourne, to Eileadh, wife of F. R. Kilpatrick, M.S., F.R.C.S.—a daughter (Fiona Morton).

EDS {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

"UNSUITABILITY shall be the sole barrier to anyone desiring to study Medicine"; this statement from the Goodenough Report raises a very controversial point. On what standards can we judge the man who wants to become a doctor? Sir William Jenner demanded three outstanding qualities: "He must be honest, he must be dogmatic and he must be kind." But these alone, admirable as they are, are not enough—above everything a doctor must be a constant seeker after knowledge and truth; in short, he must remain a student throughout his whole life. The rigid mental celibacy and self-denial that Osler demands of the student and young doctor are theoretically sound and are, no doubt, the goal towards which all should strive, but for us lesser men a more practical and less Utopian ideal should be propounded.

To revert to the subject of the choice of a medical student; it will be hard for a Selection Committee to assess the qualities of a boy on one interview or even at the end of a year's study. I have asked many students why they took up Medicine and have found, in the majority of cases, that their choice was based on the flimsiest whims; many bowed to parental pressure when they were schoolboys; and others joined their school friends at the university or in hospital, more out of a sense of comradeship than a desire to read Medicine. This state of affairs can only be remedied by fixing a later age for starting the course of study—ideally one would like to see no one starting Medicine until he had obtained a degree in some other unallied subject. In this way he would be a fuller man and more fitted to choose his vocation in life than he was when still a puling schoolboy. This scheme, however, necessitates Government grants, and although we can spend thirteen millions a day on war it is unreasonable to demand the extra expenditure of public money on matters concerning health.

ON Wednesday, October 11th, and on the two subsequent nights, Tom Hills gave us another of his inimitable revues in the Old Pathology Theatre, being supported by a wealth of local talent. Our dramatic critic has kindly written the show up for this week's issue, but the photographs which we were hoping to publish were not the success we had expected owing to insuperable technical difficulties, and have had to be omitted.

WE are now able to disclose the extent of the damage suffered by Guy's and its possessions in the recent attacks by flying-bombs. The Hospital itself was hit by nothing more dangerous than an expended anti-aircraft shell on the first night of the attack; this went through the roof of the Out-patients' Department and shattered a water main. Damage to buildings around the Hospital was fairly extensive, and Front Surgery and the Theatre were kept very busy for a spell. The playing field at Honor Oak Park took the brunt of the attack so far as Guy's was concerned, but so assiduous were the helpers in clearing up the damage, inspired by the exhortations of Harold and the Secretary of the Rugger Club, that no delay was caused in the opening of the Rugger season. We are glad to hear that Alf, who was injured by the explosion, is now making a satisfactory recovery in hospital; other casualties included two cats and a rabbit.

OUR recent appeal for correspondence and literary effort has borne fruit; we are sorry that publication must be delayed, however, owing to paper shortage.

Congenital Heart Disease in Identical Twins

By MAURICE CAMPBELL, O.B.E., M.D.

MUCH thought is being devoted to praiseworthy attempts to improve the environment in which the next generation will be brought up. An owner of race-horses is also anxious that his horses should have the best possible environment but this does not prevent him devoting time and money to the choice of prospective parents if he wishes to breed a Derby winner. The doctor—I would like to say as a trained biologist, but perhaps I should be on safer ground by saying as a student of biology—must remember that it is his duty to preach to the public the truth of biological laws and not least amongst these the importance of heredity.

Especially since the time of Galton, the founder of eugenics, many have realised the value of identical twins for a study of the relative importance of inheritance and environment, or of nature and nurture, as Galton preferred to call it.

In recent journals I have noticed accounts of subarachnoid hæmorrhage in identical twins (O'Brien, *Brit. Med. Journ.*, 1, 607, 1942); of catatonic stupor with mental deterioration occurring in both of a pair who had been separated soon after birth (Kallman, *Genetics of Schizophrenia*, New York, 1938, p. 1207); and of similar dysrhythmias in the electro-encephalograms of two identical twins, only one of whom had epilepsy (Lowenbach, *Johns Hopkins Hosp. Bull.*, 65, 125, 1939). Those who are interested will find extensive and detailed studies in a book by Newman, Freeman, and Holzinger (*Twins*, University of Chicago Press, Chicago, 1937).

The following pair of twins is reported partly becuase of some striking similarities in their medical histories, and partly because there are few records of congenital heart disease in identical twins. K. Shirley Smith (*Arch. Dis. Children*, 4, 330, 1929) described patent ductus arteriosus in a pair, both of whom died with bronchopneumonia, aged twenty-five and thirty-three days, and he quoted Pezzi's case of identical twins with dextrocardia.

Mrs. A., aged forty-two, consulted me in February, 1938, as to whether she could safely continue with her pregnancy in view of her heart disease. The heart was a little enlarged with a rough systolic murmur; but I thought there was no great danger, and her pregnancy passed to a satisfactory conclusion. Six months after this she came again at my request with her sister for examination, as she told me that her twin sister was supposed to have exactly the same heart disease. The findings in the heart in each case, and the other resemblances were sufficiently striking to suggest that there was here an excellent example for studying the relative importance of heredity and environment in twins, aged forty-two.

Personal History.—They were born in 1896 and, until the age of twenty, were never separated except that one had scarlet fever when the other did not. Mrs. C. twice got a little ahead of her sister at school, but was caught up again in the Senior Cambridge. By this time certain differences in temperament had developed and Mrs. C. decided not to be a schoolteacher, which was rather expected of her owing to the family connection, but to work at the War Office during the War. Mrs. A. was very keen on teaching and children, and continued as a Froebel teacher. About this time both twins became engaged, in each instance to men they had known the greater part of their lives, but again there was a difference, as Mrs. C. married soon after the end of the war and Mrs. A. broke off her engagement. Mrs. A. continued teaching at school and was not married until she was twenty-seven, four years after her sister. Both had two daughters followed by a son at about the same intervals of time, although these intervals were not exact, and Mrs. C. had one serious miscarriage after two children had been born, which necessitated an operation for curettage.

Perhaps one of the most striking coincidences is that both sisters developed an umbilical hernia during their pregnancies, and in each case it was during the pregnancy that took place when they were aged thirty—Mrs. A.'s second and Mrs. C.'s third—Mrs. A.'s strangulated soon after her child was born, and necessitated an operation at once; Mrs. C.'s gradually got worse and was operated on three years later. Mrs. A.'s child of this pregnancy weighed 8½ lb. at birth and Mrs. C.'s weighed 8¾ lb.

Mrs. C. had no more pregnancies after her third child was born. Mrs. A.'s husband died of cancer when they had three children. She married again after five years and saw me about her pregnancy three years later.

Apart from the obvious physical resemblance, and it was difficult to tell them apart except by their clothes or eyes (see later), the resemblance of voice and often the answers to questions were strikingly similar; many times when a question was addressed to one or the other it was answered simultaneously by both and almost in the same words, so I was surprised when they disagreed and started an argument as to whether they had had German measles, the only point on which they disagreed during an interview of some hours.

Medical History.—Mrs. C. and Mrs. A. both had whooping-cough when they were three years old and both had severe attacks followed by ulceration of the eyes. This seems to have been serious and troublesome in each case, and in Mrs. C. it left some drooping of the upper lid and a scar across the right eye, so that her sight was seriously limited in this eye. With Mrs. A. it resulted in some scarring of the left eye, but it was not so incapacitating as it was not so much over the pupil. This led to Mrs. C. needing glasses at eleven years as there was slight astigmatism in the good left eye; while Mrs. A. did not need them (and then only for reading) till a good many years later. For a few years before I saw them the eyesight of both had been getting rather worse.

At five years they both had diphtheria, Mrs. A. being thought to be more ill, and both had chickenpox about the same time. At eleven, Mrs. C. had scarlet fever, and Mrs. A. did not get it again as she had somehow managed to acquire it without her sister when she was four. At ten they both had mumps at the same time, and at sixteen they both had measles though Mrs. A., whose attack was again more severe, developed it two weeks later.

In 1918, when they were twenty-two, each suffered from a very severe attack of influenza, and for the first time each was told that she had something wrong with the heart. Mrs. A.'s breathlessness seems to have been less than her sister's at this time and it passed off after some months; she played hockey and netball and took an active part in games at school, and had forgotten all about her heart until after her operation for the rupture, when she was pressed as to whether she had ever had rheumatic fever. Both sisters seem to have thought that Mrs. C. had the rather worse heart of the two, but this may well have been because Mrs. A., owing to her choice of profession, had played more games and taken more exercise and was generally fitter. She was still playing energetic tennis when she was forty-two. Mrs. C. only played tennis till she was twenty-seven and gave it up because of her dyspnœa, which she still noticed going up hills or playing golf.

Both patients were troubled with muscular rheumatism when they were a little under forty. Mrs. C. thought hers had been cured by tonsillectomy; Mrs. A. thought that her rheumatism had been worse, but that massage treatment had been equally effective in curing it.

On examination, no abnormality was found except the heart murmurs and the opacity in the eyes. Both patients were short and broadly-built and rather heavy; their usual weight had been about 11 stone. In both the lowest weight in adult life had been 10 stone, reached by Mrs. A. in 1930 when her husband was dying, and by Mrs. C. in 1937, when her hsband was ill with duodenal ulcer.

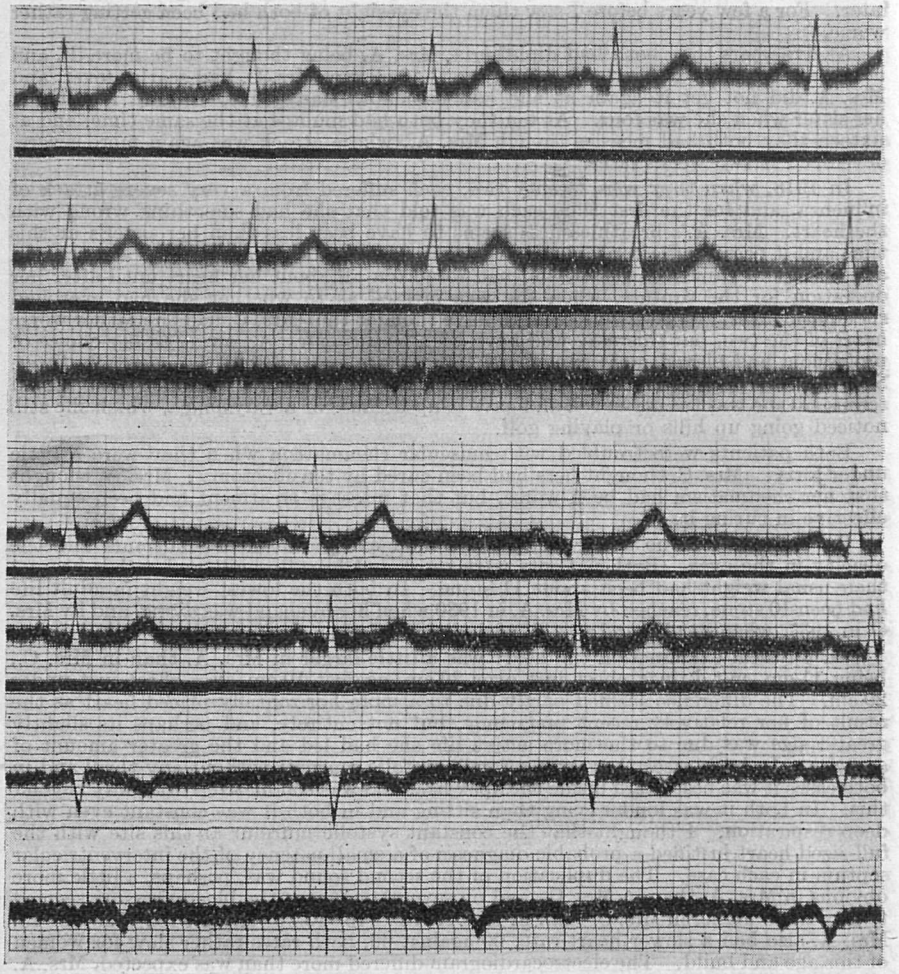
On physical examination the heart was a little larger in Mrs. A. than in Mrs. C., being 11 cm. m.t.d. in a chest just over 20 cm. against 10 cm. in a chest just under 20 cm. The difference seemed partly due to a more horizontally placed heart as the result of her relatively recent pregnancy, but not entirely, and perhaps its slightly greater size was due to the more active life she had led and the greater amount of exercise. In both cases there was a rough systolic murmur without any thrill and in both cases it was best heard inside the apex beat and was conducted a little way beyond this. In both it was louder lying than sitting and in both it was constant even with deep respiration. I thought that the constant systolic murmur at this site with the full-sized heart justified a probable diagnosis of a small patency of the interventricular septum in each case. The duplication of the second sound was, perhaps, a little more obvious in Mrs. A. than in Mrs .C., and on several occasions the blood pressure seemed to be a little higher in Mrs. C. than in Mrs. A. viz. 140–135/85 against 135–125/80–75. Mrs. A. also had a slower heart rate, 60 against 66, both rates rather slow for women of this age and build. The electrocardiogram differed more than was expected, Mrs. A. showing left ventricular preponderance with some inversion of T in lead III, and Mrs. C. showing a very low voltage in QRS III, with an inverted T wave. Leads I and II were almost identical in each case, except that the P waves in lead II were less marked in Mrs. C. Mrs. A.'s lead III a year before, during her pregnancy was however, almost identical with Mrs. C.'s (Fig. 1), both even showing an inverted P.

The eyes and heart were in each case the only pathological findings, apart from the scars of the operation for hernia. The general physical resemblance has been mentioned. The condition of the teeth and certain physical measurements added to this; the result of the blood count showed resemblances and differences.

Mrs. A. had still seven teeth on each side in her upper jaw; Mrs. C. had five on each side. Mrs. C. had seven on the right and six on the left in the lower jaw. Mrs. A. had eight on the right, but only three on the left; she insisted, however, that the others had been removed by a stranger and not by her regular dentist.

Some measurements (in centimetres) gave close agreement. Mrs. C. was generally considered slightly the smaller, and Mrs. A. had lost some weight recently after the birth of her baby.

	Head	Neck	Above elbow	Wrist	Knee	Ankle
Mrs. A.	58	36–38	24.75	15.5	37	23.5
Mrs. C.	58	35.5–37.5	24	15.25	38.5	23.5



The upper electrocardiogram was from Mrs. C. The lower one, similar except for lead III, was from Mrs. A., six months after her confinement. The lowest curve (lead III only reproduced from a faster plate) was from Mrs. A. during her pregnancy, and is almost identical with lead III of Mrs. C., the P wave being inverted in each and the other waves of low voltage.

The blood counts agreed generally except that Mrs. A. had a rather low polymorph count with a relative lymphocytosis.

	Hb.	Red cells (millions)	White cells	Poly-morphs	Eosino-phils	Baso-phils	Lympho-cytes	Hyalines
Mrs. A.	85	4.3	5,000	48	1	2	42	7
Mrs. C.	80	4.3	6,400	61	1	1	31	6

Summary.—In the pair of twins described the environment was similar till they were twenty-three and not very dissimilar through life, so that they cannot provide striking evidence of the relative importance of heredity and environment. But even allowing for the similar environment, rough systolic murmurs, probably congential, in rather broad hearts, the development of umbilical hernias at the age of thirty during pregnancies, and corneal scarring following whooping-cough, added to the general physical and mental resemblances at the age of forty-two provide a curious instance of the enormous importance of inheritance.

Sea Diseases

Sea Diseases. By R. S. ALLISON, V.D., M.D., F.R.C.P., Commander R.N.V.R. Published by John Bale. xxiii 218 pp. *Price* 25*s*.

IT is hard to see why a book of this size without either exotic binding or expensive coloured plates should be priced so high when such is its merit, interest and quality that it is sure of a wide sale among not only those at present engaged upon naval medicine and those who will be going to sea as medical officers in the coming years, but all who are interested in the sea and the great part medicine has played in keeping our fleets in action, and in doing so, our country free. It is to be hoped that the publishers will reissue this book at a much reduced price as soon as the present printing is exhausted; their bolder policy would not go unrewarded. Readers of the *Gazette* who are going into the Naval Medical Service should disregard the cost and devote their first day's pay to buying "Sea Diseases"; they will not regret doing so. In the Foreword the Medical Director General, Sir Sheldon Dudley, F.R.S., remarks: "I hope that at least every surgeon-lieutenant will read and ponder this book before he takes up his first appointment as medical officer to one of His Majesty's ships"; it would be an impertinence to say more in this respect.

The story of Dr. Thomas Dover, physician-privateer of Bristol in the eighteenth century is told in full. (I must admit to using the epithet "pirate" for him, which is entirely incorrect.) Here is the original recipe for Dover's powder, and here we learn that until an advanced age the doctor used the Jerusalem coffee-house in the Strand for consultations. However, while Dover secures pride of place for romantic splendour, it is to men like Lind, Trotter and Blayne that the naval medical service is indebted for the careful observation and enunciation of principles which enabled scurvy, the scourge of sea-farers, to be eliminated, typhus greatly reduced, and the health of the sailor to be greatly improved.

It is striking how often a passage from an earlier age appears vividly reminiscent of life in an old destroyer in this war. Here is Smollett, writing of an evening round in a ship during the eighteenth century: "Here I saw about fifty miserable distempered wretches suspended in rows, so huddled one upon another that not more than fourteen inches space was allotted for each with his bed and bedding, and deprived of the light of day as well as of the fresh air, breathing nothing but the noisome atmosphere of morbid steams exhaling from their own excrements and diseased bodies, and destitute of every convenience necessary for people in their helpless condition. . . . I could not conceive how it was possible for the attendants to come near those who hang on the insides towards the sides of the ship in order to assist them . . . . much less could I conceive how my friend Thomson would be able to administer clysters that were ordered for some in that situation, when I saw him thrust his wig in his pocket and strip himself to the waistcoat in a moment, then creep on all fours under the hammocks of the sick, and forcing up his bare pate between two, keep them asunder with one shoulder until he had done his duty."

One surgeon-lieutenant at least will always remember keeping the hammocks asunder with his shoulder, balancing precariously on a bench or mess-table while clinging hard with one hand for support against the pitch and roll of the ship. Ventilation has improved; few of us have to give enemata to those in hammocks, but the picture is otherwise not unlike a small ship with the 'flu on board in these days

when war has caused much overcrowding. Oddly there is no mention of the ship's movement in this passage.

Here, too, is an account of the heroic surgeon Mackinnal, who, in order to demonstrate to a demoralised crew that yellow fever was not contagious drank a wine-glass of black vomit, since he had to rely upon the assistance of the men to nurse his sick, there being no Sick Berth Branch in those days. A brother surgeon wrote at the time: "It is almost unnecessary to add that it did not impair his appetite for dinner nor did he suffer any inconvenience after it." Commander Allison has done well to give this gallant naval surgeon his proper place in the annals of yellow fever research, for it was no piece of idle bravado. Mackinnal, after careful study, had noted the effect of altered climatic conditions upon the course of the disease.

It would be possible to go on quoting, to discuss the changing status of the sea surgeons from that of a rating, to warrant officer and, finally, to commissioned rank just over one hundred years ago; to follow the struggle waged by the Royal Colleges and successive Director-Generals to increase the efficiency of the Naval Medical Service with an Admiralty not always co-operative, encouraging or understanding.

The book ends before the last war and this emphasises how much a sequel covering the last fifty years is needed, showing how the increased range, speed and size of ships have altered the problems of naval medicine and surgery. It is hoped that this logical step will be taken by the author who is qualified by both experience and inclination for such a task.

In the meanwhile one wonders where are our modern counterparts of the "Surgeon's Mate" by John Woodall, one-time sea surgeon and Master of the Company of Barber Surgeons, from whom it seems that "the most frequent diseases at sea are wounds, Aposthanes, Ullcers, Fistulas, Fractures, Dislocations," and that who gives information about "the true manner of amputation, the care of the scurvie, Fluxes of the belly, of the Colics and Iliac Passio, Tenesmus and exitus ani, Callentures?" Where are our modern versions of Cockburn's "Sea Diseases" or Trotter's "Medicina Nautica"? True the specificity of the sea diseases is reduced; that scurvy has long ago been conquered; and that we have fuller understanding of the great epidemic diseases, but there is need of a book written for the unchanging difficulties of weather, isolation, inadequate equipment, shortage of skilled assistance, and lack of technical dexterity due to little practice which have often been the sea surgeon's bane in the past.

It may be argued that the time is past when we should worry about such things, but the Pacific is larger than the Atlantic, given to storms of no less violence and includes in its battle area a great range of climatic difficulties; if by providing information in a relevant, compact, concise and up-to-date form such a book assisted in saving the life of only one sailor, it would surely have been worth while? A collaboration between a surgeon and physician, both with sea experience and with the results of the treatment of illness at sea in front of them would be the ideal combination; perhaps the author of this admirable book will add his experienced voice to your reviewer's plea.

"SINBAD."

Autumn in the Wildernesse

THERE'S a whispering in the tree-tops as the golden leaves are falling,
The brittle copper carpet rustles softly round their feet;
A late and lonely blackbird for its winter home is calling,
The sun that gilds the trees with glory shines without its heat.

There's a squat and hollow oak-tree with its arms grotesquely bending,
Its gnarled and wrinkled body shows the years of its decay;
See, round the writhing roots the rust-brown bracken is defending,
While Autumn with relentless progress steals his cloak away.

Is Autumn sad? Not to the heart that knows the trees but sleep to wake.
This death is not to lose their life, but find it, multiplied;
And not to die is but to live alone. I'll pleasure take
In Autumn, patient, till in green I meet her beautified.

Is parting sad? If parting were for good it then would break my heart.
But for a while I sleep, yet my heart's prayerful for thy sake,
That God would watch between us, helping each to live for Him apart,
Till sunshine kisses me once more in Spring—and I awake!

"WILL."

Correspondence

APPOINTMENTS AT GUY'S HOSPITAL.

To the Editor of the GAZETTE.

SIR,—I wish it to be understood at the outset that the opinions expressed in this letter concerning the filling of posts at Guy's and at the various Sector Hospitals are general and in no way personal.

Recently Dr. T. B. Johnston kindly gave those who were due to qualify a short talk on why we should apply for sector posts, but nothing concrete materialised from the talk and the situation was far from clarified.

The main causes of dissatisfaction are as follows :—

1. *At times the selection of house-officers at Guy's and at some of the base hospitals* has left much to be desired. Admittedly here the problem will never be solved to the satisfaction of all.

2. The salary of £100 per annum or thereabouts is extremely small when compared with similar posts at other hospitals.

3. This is main cause of discontent and prevents many newly qualifying men from applying for a sector post. It was so in my case. The system whereby if one applies for four or five sector hospitals one must automatically apply for the rest is dictatorial and, if the shortage of housemen is to be remedied, some change will have to be made. Newly qualifying men just won't take the chance of being appointed to one of the more unpopular sector hospitals when he can choose his own post outside the sector. Surely this attitude is reasonable. Why should one apply " blind " for a post ? We all understand that Guy's is committed to fill the sector hospitals, but surely some other form of selection will have to be worked out, or the more unpopular sector hospitals deleted from the list.

Yours, etc.,

E. W. R. ALDERMAN.

Guy's Hospital, S.E.1.

P.S.—Personally I should have preferred to have remained in the sector.

Starlet's No. 6

WE had been looking forward to another Starlets for a long while. The latest production would have been several weeks earlier but for the flying-bombs, which temporarily held up rehearsals. But as soon as these stopped coming over in any number the cast set to where they had left off. They were not even discouraged when an authoritative opinion newly returned from India, after seeing a rehearsal and being asked what he thought of the show, innocently remarked how difficult it was to tell when they were not in the proper clothes ! It was a tribute to the previous Starlets that all the tickets had been sold forty-eight hours after their release. We would like to think that at Christmas, when another edition is planned, it may be possible to borrow a larger theatre, for the demand will be no less. When it was suggested that we should write a criticism we immediately demanded a programme from the producer. " No," said he, " we don't want a catalogue "—so we didn't press him. Well, one or two things do still cause a private chortle, but many others which we laughed at heartily at the time will not return unaided. First and foremost Sidney Hilton gave a perfect idea of a " Borough type " in the " Borough Apache," and then, after many other appearances (for he was seldom, happily, off the stage) he reached a climax singing " My old Man said ' Follow the Van ' " with a gusto unrivalled since the Victorian music-halls.

There was a drawing in *Punch* not long ago depicting a corpulant female crooning complacently at a fashionable hotel. Below it was a drawing of an acrobatic team performing a prodigious defiance of gravity while juggling electric light bulbs with the superfluous limb. But the months of practice behind this feat were nothing, for it appeared only a matter of time before the crash came. These drawings were captioned " Success " and " Failure " respectively. And that was our criticism of the chorus or, rather, not the chorus itself, but the idea of a chorus. They were embarrassed and so were we. Their costumes were, however, a masterpiece of inventiveness and good taste.

The songs and sketches were mostly composed by Tom Hills, who excels at that sort of thing—"The Elephant never Forgets"; "But, Maisie, why a Dental?"; the music of the rehearsal scene; the sketches "Not in York Clinic" and "The Disjoint Board." Mike Hall added one or two of his own compositions, and his "Hats Off to You" sounded better than most things we have heard in the West End recently. Tony Reeves prattled the story of the "Soles" and drilled the squad so fluently that he would be at a premium in Germany for the training of their new Home Guard. Miss Hall, draped in a blanket, sang a song by Tom Hills about losing her frock. Apparently, on the first night, after dining at the "George," her modesty overcome, it seemed that far from being shaken by her loss, for tuppence she would dispense with the blanket also!

But this is rapidly becoming a catalogue—suffice it to say that it was a most enjoyable evening and we would congratulate all those who had a share in the production, both on and off the stage, on the excellence of the performance.

"ἀμυλρη"

Hospital Information, etc.

Notice

SOCIETY OF APOTHECARIES OF LONDON.

Colonel Elliott C. Cutler, M.C., F.R.C.S., Chief Consultant in Surgery, United States Army, European Theatre of Operations, will deliver a lecture on Military Surgery in 1944 at Apothecaries' Hall, Black Friars Lane Queen Victoria Street, E.C.4, on Friday, November 3rd, 1944, at 2.30 p.m. (Members of the medical profession and senior students are cordially invited.

WORKMEN'S COMPENSATION ACT, 1925.

The Secretary of State for the Home Department gives notice that in consequence of the death of Dr. W. A. Brend, of 14, Bolingbroke Grove, S.W.11, he is considering the appointment of a Medical Referee under the above Act for the County Court Districts of Uxbridge (Circuit No. 34), Shoreditch and Windsor (Circuit No. 39), Bloomsbury (Circuit No. 42), Westminster (Circuit No. 44), Kingston-on-Thames and Wandsworth (Circuit No. 45), Woolwich (Circuit No. 47), and the City of London.

Applications for appointment should be addressed to the Under-Secretary of State, Home Office, Whitehall, and should reach him not later than 6th November, 1944.

Whitehall,
11th October, 1944.

Blues

The following awards were made at the recent Blues Committee meeting:—

Cricket.

Full Blue: G. Thompson, L. D. Carton-Kelly.

Half Blue: A. E. Trist, E. W. Graham, D. J. Sheerboom.

Tennis.

Full Blue: R. G. Lomax, P. E. Mars, R. Freeman, K. Y. Khong.

Half Blue: P. R. D. Dwyer, E. Filose.

Sailing Club.

Half Blue: D. J. Murch, G. B. Elphicke, D. J. Reid.

Boat Club.

Half Blue: C. C. Bull, A. A. Shotts.

Boxing Club.

Half Blue: J. R. Burt, C. H. Kinder, J. Shaw.

E. G. MURPHY,
Hon. Sec., Blues Committee.

Pass List

UNIVERSITY OF OXFORD.

SECOND B.M. EXAMINATIONS.

Long Vacation, 1944.

Forensic Medicine and Public Health.

J. N. Micklem A. Batty-Shaw
J. D. L. Reinhold

Special and Clinical Pathology.

J. D. L. Reinhold A. Batty-Shaw

General Pathology and Bacteriology.

R. E. Hansen.

Prize Examinations, etc.

Prize in Special Anatomy and Physiology.

The following awards have been made:—

J. B. Kirkwood .. .. Prize.
C. D. Baker .. .. Certificate.

Change of Address

M. C. Hart, Major, A.D. Corps, 58th Field Dental Laboratory, B.L.A.

G. B. Pritchard, M.R.C.S., L.D.S., 36, Queen Anne Street, W.1. Tel.: Langham 2284.

W. A. Porter, Ft./Lt., R.A.F., 3 R. & S.V., R.A.F., India.

F. McCombie, Major, A.D. Corps, 25 Ind. Div. Signals, S.E.A.C.

J. W. Robb, Lieut., R.A.M.C., 68 W.A. General Hospital, Lagos, Nigeria, West African Force.

John C. Hour, Lieut., A. D. Corps, 8, Harraden Road, Blackheath, S.E.3.

F. C. Hunot, Surg.-Capt., R.N., Royal Naval Hospital, Bermuda.

W. S. McConnell, Lieut.-Col., R.A.M.C., c/o Grindlay & Co., Bombay, India.

Deaths

DOYLE.—In September, 1944, in North-West Europe, James T. Doyle, Capt., R.A.M.C. (Airborne), 53, Burdon Lane, Cheam, killed in action, aged twenty-four years.

ELWOOD.—On September 17th, 1944, Walter Elwood, L.D.S., R.C.S., 64, Dublin Road, Belfast.

EDS {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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Vol. LVIII. No. 1469 11th November, 1944 Ninepence

PASSIM

THE vitality of any community can be measured by the number, variety and vigour of its societies. Therefore we welcome as a sign of that vitality the awakening, from their war-time sleep, of the many societies which flourished in this School before the War. Weekly gramophone recitals have been started; the Physiological Society has held its first meeting in town for some time; and the Athletic Clubs are flourishing. We hope soon to see more societies coming to life again, particularly our famous Physical Society which has such rich associations with the past.

In addition, we would urge all students, particularly new arrivals, to take their full share in the activities of these societies and not to feel diffident about joining them. The contemptuous and supercilious frame of mind is to be thoroughly despised and those who will take no part in the doings of the societies because they feel that they are above such things might well go elsewhere.

The corporate life of a medical school is one of the great benefits which it has to offer, and it would be foolish to waste such golden opportunities of meeting one's fellows and discovering how many shades of opinion can exist on any one topic, scientific or otherwise. We expect—and get—plenty of "shop" at meal-times and on rounds and casual contacts, but there are other matters of greater weight and importance which should claim our attention at the moment.

"We live in the presence of history." Thus Mr. Churchill. Indeed, the most tremendous and solemn events take place each day before our very eyes. The war in Europe and the affairs of Parliament seem to have become flesh and blood. And yet how shallow and superficial is the interest aroused.

It used to be maintained by a previous generation that doctors should not meddle in politics. But now we have no alternative. If the Government chooses to interest itself in the affairs of the profession, it seems only right that the profession should repay the compliment by interesting itself in the affairs of the Government and in politics. Perhaps we labour this point too much, but it is important enough to be worth the reiteration.

This brings us to our point. Granted the advantage of student societies and the necessity for political interest, then the logical conclusion would seem to be that there should be in this Hospital some means whereby political thinking and interest may be promoted and encouraged by debates and discussions.

Unfortunately, political consciousness is not encouraged amongst medical students. Can it be that our teachers are concerned that our studies will thereby suffer? But, surely, we are entitled, just as much as any other body, to hold views concerning the political events of the day, particularly since so much is beginning to affect us as individuals and not only as a profession?

WE regret to announce the recent death of Mr. F. Newland-Pedley, F.R.C.S., L.D.S., Consulting Dental Surgeon to the Hospital.

READERS of last week's *Lancet* will, no doubt, have seen an article, entitled "The Film in Medical Education." We have always felt that much of our teaching could be supplemented by the wise use of films, and although it can never take the actual place of the teacher and the subject, the film can be an invaluable asset to the clinician, who can thus demonstrate diseases which are not often seen in his wards, but have a very definite importance, such as tropical diseases. The teaching of public health could be made absorbingly interesting and forensic medicine realistically so.

Transfusion Fatalities

A Clinical Lecture given by F. A. Knott, M.D., F.R.C.P., on September 8th, 1944.

GENTLEMEN,—Some months ago I was privileged to put before you a number of practical points on the avoidance of transfusion reactions. (*Guy's Hospital Gazette*, Vol. LVI p. 253, 1942). Strictly speaking, blood transfusion should, as Whitby aptly remarks, be a perfect tissue graft. There should be no reactions. But this is an imperfect world and so many people are concerned in the chain leading from the initial volunteering of the donor to the actual running in of the blood that the clinical operator can only assure himself that he at least has taken every precaution. As fundamentals I suggested the three Cs—*Cleanliness*, *Calm* and *Cross-matching*. If all our apparatus is chemically and bacteriologically clean, the patient quiet and unapprehensive and his and the donor's bloods cross-match perfectly (according to both slide and test-tube methods), we can be sure of reducing the incidence and severity of rigors and other minor reactions to a minimum; at least we have minimised risk.

Now, I have used the last four words deliberately because, in practice, there still are risks; not many and on most occasions they are negligible, but special circumstances may bring them to the fore.

Therefore, to-day, I propose to describe to you very briefly a few occasions within my own experience on which the effect of blood transfusion was to hasten, if not actually, to cause the patient's death. They may, I think, illustrate the need for some second thoughts on the subject of blood transfusion. Technical perfection in running in guaranteed blood which has, like a bottle of beer, been promptly supplied on demand by someone else is not enough. Care and organisation will, as I say, cut down minor reaction, but will not, unless you carefully consider the chemical facts of each case, make disaster impossible.

OVER-TRANSFUSION.

Let us first take an example of *Hæmatemesis*. This patient, an extremely energetic business man just past middle age, I had known for seven years and first met him immediately after a severe hæmorrhage from a deep lesser curvature ulcer (Hb. 32%). On that occasion he received a single transfusion of just over one pint of fresh blood, was kept absolutely quiet, and made a steady recovery under the usual medical *régime*. In spite of warnings he soon began again to commit all sorts of dietetic irregularities and, within three years, gross hæmatemesis recurred. Once more a single transfusion of one and a half pints of fresh blood followed by medical treatment was completely successful, and for a few years, while he remembered the lesson of this second experience, he remained perfectly well with all tests for occult blood quite negative. But recently, possibly owing to the strain and difficulties of the times, he bled grossly for the third time, and again showed a hæmoglobin level of less than 40 per cent. Transfusion was again proposed, but with this modification. You will remember that within the last few years there have been many advocates of continuous very slow drip-transfusion of very large volumes of blood. They hold that not only can the blood picture be rapidly restored and convalescence shortened, but that, given in this way, a given volume of blood produces a greater rise in hæmoglobin level. Therefore, following this patient's third hæmatemesis, slow drip transfusion of four or more pints was undertaken. Put briefly, nothing untoward happened during the first two pints. The third produced some restlessness, which I now feel should have been a warning, and, during the fourth, the patient, who now looked and said he felt enormously improved, was becoming increasingly talkative when the disaster happened—the largest hæmatemesis I have ever seen almost immediately followed by two smaller ones. The patient died that night. I leave you to draw your own conclusions. Continuous drip-transfusion of large volumes has its obvious applications, but beware of the large, only recently closed vessel. Only this week I saw an almost exactly similar case most successfully dealt with by slowly transfusing at first only one and a half pints of blood. He was then taken to the operating theatre with the transfusion apparatus still in place. The surgeon proceeded to partial gastrectomy, giving the order for transfusion to be resumed the moment surgery had rendered impossible further hæmorrhage from the vessel deep in the crater. A further two pints were at once given. Clinically this second case has been a complete success.

SUB-GROUP INCOMPATIBILITY.

The second fatality I describe is of more unusual type. So much has recently been written concerning the very rare chance that a person receiving a second transfusion after some months may disclose a sensitisation towards the Rh factor or one of the unusual blood sub-groups that I need only remind you of it. The same principle prompts the warning that transfusion of pregnant women needs care. Here the sensitising factor lies in the fœtus and the same factor, if present in the donor's blood, may produce alarming effects on the mother. We have, at Guy's, recently met with one of these Rh factor fatalities. It was serologically fully investigated and the results confirmed at both the Sector 7 (Dr. Loutitt) and Sector 10 (Dr. Maizels) blood transfusion depôts, and the details, and particularly the insidious onset of this type of reaction, will, I think, interest you. Again we are dealing with a case of recurrent peptic ulcer in a man. Four years previously he had received two blood transfusions. His own blood was Rh negative. One donor had been Rh positive, although this was not known until later. Admitted to Guy's for surgical treatment he received a preliminary one-pint transfusion. It cannot be said that he took this badly, but he was sufficiently restless to to cause the house-surgeon to stop the transfusion just before the end, keep some blood from both patient and donor, place the samples in the refrigerator and bring them to me next morning. We cross-matched them by slide technique and everything seemed perfect. We then tried again by the test-tube method of Taylor and Race, and were suspicious that very slight agglutination of the donor's cells occurred in the patient's serum. Meanwhile, over four days, the patient *slowly* developed all the signs and symptoms which ordinarily *quickly* follow transfusion with grossly incompatible blood. He died, moderately jaundiced, on the fifth day. Post-mortem examination showed the fairly typical liver, kidneys and spleen which I have recounted here. Fortunately, samples of the patient's blood had been taken daily and preserved. Put briefly, examination of these showed the donor to be Rh positive. Although just before receiving this last Rh positive transfusion, the Rh negative patient had only traces of Rh agglutinin in his serum, the titre rose day by day until a really strong reaction was obtained in his blood when collected just before death. This finding corresponds exactly with the slow development of the clinical reaction and emphasises the need to use Rh negative donors for Rh negative patients and pregnant women who have ever been transfused in the past. Nowadays, through the kindness of Dr. Allott, of Lewisham Hospital, we are able to have Rh groupings quickly determined. This case should also remind us of the value of test-tube cross-matching which, had it been done in the first place, was evidently able to give at least some indication that the initial match was not perfect.

GROSS INCOMPATIBILITY.

The third case I will relate as illustrating how a very small lapse may disastrously wreck everything. Before the days of organised central donor panels and storage depôts, hospitals had often to rely on relatives. Frequently patients preferred them. Each relative had to be grouped on the spot, and accordingly the wards were regularly supplied with standard group A and B sera sealed up in pairs of capillary tubes. A particular Group O patient, suffering from a refractory but simple microcytic anæmia, asked that if she were transfused her brother should act as donor. He had some distance to come and his visit for grouping had twice to be postponed. The apparatus, including the tubes of standard sera, had been put out ready for the *first* appointment. Unfortunately they remained out until he arrived thirty-six hours later. Meanwhile the summer sun had on its course shone on the serum tubes. When the test was made neither serum agglutinated the brother's cells; he was therefore classified as Group O and used forthwith as a donor. Subsequently he was retested with fresh sera and found to belong to Group A. I need not continue the story or point the moral further.

OVERHEATED BLOOD.

I sometimes wonder whether we all appreciate the extreme danger which lies in overheating stored blood. It is certainly one of the most active of the hornets which Dr. Keith Simpson reminds us may nest in an E.M.S. bottle. I know of two patients who collapsed and died after receiving less than 150 c.c. and, on each occasion, the sister, the transfusion being suddenly stopped, had dismantled the apparatus and at once placed the possibly offending bottle in the refrigerator, thus "fixing" its condition at the time. Brought to me next morning the blood in both these bottles was, though recently collected, dark, quite hæmolysed and obviously overheated. I will pass round

a bottle of stored blood just heated to 50 deg. C. for ten minutes, and I want you to notice, by comparison with this ordinary fresh bottle, its changed appearance. I know it is not easy to see these changes in dimly lighted, blacked-out emergency wards—and that is the origin of the cases I quote—but too much care cannot be taken to avoid even the chance of overheating. Trouble is easily caused by a nurse who does not appreciate the reason for the official 40 deg. C. limit. And beware of such bright ideas as one recently encountered—namely, standing a reserve bottle next to the ward radiator! The official memoranda tell us that overheated or once frozen bloods are liable to "cause reactions," but it would be justifiable to use very much stronger terms, particularly as regards the effect upon a patient who is already in a bad way and whom we are indeed supposed to be resuscitating. Remember that a very hot water bottle placed near or over the transfusion tube can do as much harm as heat applied to the bottle itself.

ALLERGY.

Just one further occasion I should like to describe to you—namely, the transfusion of known allergics. It is the common experience that the incidence of urticarial wheals and other minor reactions tends to rise with each successive transfusion on the same patient. If the patient gives a history of allergy, commonly of hayfever or asthma, this tendency becomes even more noticeable even though the donor may himself be apparently free from any form of hypersensitivity. If the typical history is there or early in the transfusion marked urticarial reactions begin, go carefully. A case comes to mind in which a middle-aged woman with inoperable renal neoplasm was advised to have occasional transfusions to maintain her general condition. She gave a long history of hay fever and bouts of true asthma. The third transfusion, stopped after less than 100 c.c., produced such severe shock of the anaphylactic type that, although she survived the immediate effects, it was with little surprise that we heard of her death four days later. This is, perhaps, an extreme instance, but it will illustrate my point.

And so I come to the end of my time and my sketch of these few fatalities selected, not with a view to any academic classification, but just as they occurred in ordinary blood transfusion practice—a record of failures. They gave me much to think about at the time. I hope they will, as a practical record, have interested you. Remember that, even though every part of your own transfusion procedure appears to be technically correct and the supply services perfect, yet, as clinicians, you still have many things to watch and consider before you can be quite sure that your patient will really receive the benefit you intend.

The Dental Society

Presidential Address by A. B. Aldred, Esq., L.D.S.

THE President suggested that a greater proportion of papers read to the Society should be contributed by students since this was the original aim of the Society. At present, a large proportion of papers were read by one of the highlights of the dental world, and students tended to accept, without question, such papers, which contained, perhaps, more knowledge than was necessary for their immediate requirements.

Dentistry, he said, was a profession making great demands on the practitioner, even more so, perhaps, than the practice of medicine and surgery. In nearly every case, while we did not hold the patient's life in our hands, we had to deal with a very nervous patient. His address would, therefore, be upon a subject barely touched on in hospital training—namely, management of a private practice. He had been practising dentistry for twenty-five years, and although he had learned much during that period, he still met patients whom he found difficult to handle.

Patients were at a disadvantage from the start, as whereas the operator was at home in his own surgery, the patient found it foreign and associated with pain. However, they usually arrived on the recommendation of someone whom the operator had already treated, and this implied that that patient, at least, had found this operator congenial to him. Provided one obtained the confidence of the patient and fully exploited the fact of recommendation, most patients would return again and again.

It was most important, he said, to be punctual in keeping appointments, and to impress the patient that he is all-important and that the dentist was completely at his

service during the time of the appointment. For a first visit he allowed thirty minutes, unless the patient required urgent treatment, when he told the patient that it was a short appointment and how long it would last. In general, patients disliked short, hurried appointments, and one should never give the impression of being in a hurry.

At the first appointment he ascertained whether there was anything to which the patient particularly wished to draw his attention and dealt with it immediately, if possible. If there was nothing, he examined the mouth systematically, clinically and with X-rays, and filled in any spare time with a prophylaxis. When making the next appointment, he decided what he would do, estimated how long it would take, and fixed up accordingly. The patient was then given a card with the day, date and hour of the appointment written upon it. While he was doing this, his secretary-assistant cleared away used instruments, closed drawers and tidied the room. Provided the operator worked cleanly all this could be done while the patient was arranging for his next visit. Instruments were unobtrusively sterilised while the following patient was being treated; this necessitated a duplication of all instruments which are in constant use—in any case, reserve sets should always be available for emergencies.

The President then said a few words on the personal appearance of the operator. He should be smart and well groomed, and should always wear a clean white coat. Personal oral hygiene, of course, should be beyond reproach. It was important that we should not breathe heavily on the patient, and he used an antiseptic mouth-wash frequently throughout the day.

Equipment was an investment, as by its use the dental surgeon lived. It should always be kept in good working order. The waiting-room should be a comfortable place and the magazines should be kept up to date. He endeavoured to work to time and avoid keeping the patients waiting, but, when he did, he always sent his secretary with his compliments and apologies, with an estimate of how long he would be.

In conclusion, the President regretted that the time available only allowed him to deal with a few points bearing on this subject.

Pembury Letter

THERE has been no Pembury Letter for many months and so much has happened in that time that it will only be possible to mention the more notable events.

We shall begin with the customary affectionate references to our house officers. Doctors George Gilford and Sharpe have recently left and Doctors Palmer and Meredith Brown have joined the staff. We were also sorry to lose Dr. Enderby. His place as anæsthetist has been taken by Dr. Cook, who has already distinguished himself in the unusual rôle of umpire in a memorable cricket match to which we shall shortly refer.

Here, in the heart of Southern England, we have had every opportunity to study the flying-bomb at close quarters—sometimes uncomfortably close. "It can now be revealed," however, that the only damage to the hospital was caused by nine members of the resident staff trying to look out of the same window at once as a bomb passed over!

A number of successful dances have been held in the Nurses' Home. In addition, several excuses were found to hold celebrations at the British Legion Hall. Gramophone recitals have also proved popular; the most recent was given by Mr. Walter Gilford.

An extraordinary cricket match took place on the local ground between a team of sisters and nurses and a staff and students eleven. The gentlemen won by several wickets after dismissing the ladies for a paltry thirty. Among the more outstanding feats were those of Dr. Morton Evans, who took two wickets in one over for no runs; and of Dr. Sagorin, who fielded with great brilliance in the long grass. Mention should also be made of a fighting innings of 11 by Nurse Kingham and of a graceful late cut by Nurse Edmonds, who, though missing the ball, succeeded in shattering her wicket. We were pleased to see Dr. Grasby and Dr. Schmelz among the spectators, though the latter's comments on the play indicated that he is still not clear on some of the points of difference between our national game and Rugby football. Richard Neve, by whose energies the match was arranged was unlucky to be bowled first ball by a half-volley which came rather quickly off a dandelion patch.

The ladies being anxious to recoup this loss, a tennis match was promptly arranged. However, they fared little better and afterwards a mixed doubles contest was held, which produced some much closer games. In the end Mr. Walter Gilford and Nurse

Kingham overcame Dr. Sagorin and Nurse Simpson. Nurse Kingham served with great speed and accuracy, and all the players showed considerable skill in playing difficult balls as they came off the acorns on the court.

We send our good wishes to all our friends at the other sector hospitals and lapse into silence again with the hope that this may be the last war-time letter from Pembury.

I. A. H. M.

Correspondence

RECONSTRUCTION OF GUY'S HOSPITAL.

To the Editor of the GAZETTE.

SIR,—The articles in a recent number of the *Gazette* by the Superintendent and by the Architect dealing with the rebuilding of the new Guy's, raise many difficult problems affecting the future of Guy's for centuries. Before everyone can concentrate on the detailed plans that are of such vital importance in a hospital, two broad general questions must be widely discussed and generally accepted. These are the destruction or retention of what remains of Guy's original buildings, and the site of a modern hospital. Should it be built in cramped space in a crowded area, or in the country, where the architect can really have a free hand?

Correspondence in the *Gazette* earlier in the War showed how deeply many Guy's men feel about the retention of the original buildings, though for many years before the War there had been discussion as to whether they could ever be modernized, or even whether they could be made structurally safe for the future. At first sight the limitation of the damage to the actual area bombed suggested that the buildings were structurally sound and seemed to strengthen the hands of those who wished to keep the old buildings, but the much more extensive damage that followed the fires in April, 1941, destroyed the east wing of the front quadrangle, including the Court room with its beautiful old staircase, and meant that there were only two alternatives—complete demolition of the old buildings or a most expensive reconstruction imitating the past. Much as I loved the old buildings I am persuaded that any reconstruction with modernization of the wards would be most difficult, if not impossible and unjustifiable, because it would be more expensive than complete rebuilding. Other parts of the Hospital built more recently have never acquired the same sentimental attachments for many Guy's men, and in my view have not the beauty of the original buildings, but the particular points at which the bombs fell have, I fear, settled the question, and there is now no choice but to accept the complete demolition of what remains of Guy's original buildings and to start again. By replanning a colonnade with a shorter front quadrangle, and working from the crypt which remains, the architect is doing as much as is possible to retain the spirit of the past. The new plans must therefore be discussed without considering the alternative of maintaining the Guy's original buildings.

At first sight there is much to be said for a modern hospital in the country, where the architect can have a free hand to build a hospital as he thinks it should be without being cramped by a site that is both limited in size and shape, so that many may wonder at the decision to rebuild in St. Thomas' Street. By chance at one of the main meetings where this was discussed, the chairman took the unusual course of asking every member present to speak in turn before there had been any general discussion. Every single member—and it was a well-attended meeting—was in favour of rebuilding on the old site. I think the overwhelming motives that led to this were threefold: First, the advantages for the patients and their visitors in a central accessible site. Secondly, the certainty that there must be no separation—(*a*) between out-patient and in-patient departments; (*b*) between hospital and medical school; and (*c*) between central hospital and a country hospital, because any such separations prevented the close contacts and frequent meetings between so many members of different departments that are essential to the best work of a good medical centre. And, thirdly, the intellectual isolation felt by those who had worked in the country hospitals during the War, partly because a visit to the library, or a medical meeting, or a committee, seemed to take half a day, or even a whole day, instead of the actual hour or two involved, and because the meetings at meal-times and in the Colonnade where so many informal discussions took place, were limited or absent. It is true that many patients evacuated to the country are less hostile to the idea after they have experience of it than they were before, and that their visitors did not find it as difficult to see them as

they expected, but even with these patients there were nearly always drawbacks in the lack of continuity. This does not mean that there should not be a large country branch, but does mean that the main hospital should not be away from the general medical centre. Possibly these arguments do not apply so decisively to a smaller town than London.

In my view, therefore, the plans for the new Guy's should be discussed with two fundamental assumptions. Firstly, that we have, unfortunately, lost the original hospital built by Thomas Guy and loved by so many generations of Guy's men. Secondly, that the Hospital must be rebuilt on its old historic site near London Bridge, where it can continue as the local hospital for the inhabitants of Bermondsey and Southwark, and also as a great medical centre for a much wider area.

Yours, etc.,

MAURICE CAMPBELL.

THE LATE SIR ARTHUR HURST.

To the Editor of the GAZETTE.

SIR,—Many members of the profession were attracted to Hurst's famous "combined rounds," and these included the great and famous from all over the world. I believe, however, I can confidently claim that of all who sat at his feet and were privileged to participate in discussions, nobody can have been more regular than I in attendance, and nobody more appreciative.

In the golden days before this War, I never missed a Tuesday afternoon for years. I had the supreme privilege of debating the treatment of arthritis with Forrestier; of crossing swords with Finsterer on the subject of gastric ulcer; of discussing anæmia with Castle himself. And even with Hurst in solitary authority, I do not recall a single occasion when profitable employment was not allied with intense pleasure. Notwithstanding the considerable difficulties of recent years, the rounds hardly diminished in quality and enthusiasm. I am glad to reflect that I was present on the very last occasion when he came to Guy's.

It is not my intention to attempt to supplement the eloquent and moving panegyrics contributed by his immediate colleagues, Ryle and Witts. But I would beg the hospitality of your columns to express an appreciation, not only to Hurst himself, but to Guy's generally, for their kindness to me during these many combined rounds. Courtesy to a visitor I expected, but I received far more than that. Members of the staff, registrars, and students, one and all, combined to express an assurance that I was always welcome.

It was even generously represented to me that there were occasions when I paid my way with contributions of some little value. Feeble as they might be, they presented views from a different school. And opposition to the master—sometimes, I admit, deliberately undertaken—educed a counterblast which, whilst entertaining the audience, provided instruction as a dialectical exposition such as he himself greatly enjoyed.

Arthur Hurst has gone, but so great and widespread was his influence that his spirit must surely survive. Perhaps the tradition may be perpetuated by an attempt to continue his combined rounds. These could not be expected to possess the same quality; even Guy's cannot produce many Arthur Hursts. But I think he would regard the attempt as a tribute and with that touch of modesty which characterises the truly great, sympathetically to approbate the struggles of the ordinary man and acclaim his results far above their real value.

Yours, etc.,

ADOLPHE ABRAHAMS.

86, Brook Street,
Grosvenor Square, W.1.

ROYAL MEDICAL BENEVOLENT FUND.

To the Editor of the GAZETTE.

SIR,—Once again it is my privilege to appeal to your readers throughout the country to remember the beneficiaries of the Royal Medical Benevolent Fund during this coming Christmas. These beneficiaries are aged or infirm medical practitioners, their widows and dependents, and as an old man myself—now in my hundredth year—I have their welfare much at heart.

It has been my custom for many years to appeal for Christmas gifts on their behalf and a large sum must be raised if we are to give £3 to each, as we would like to do, and as we succeeded in doing last year.

If my colleagues could read the warm expressions of gratitude which are received each year they would feel that their contributions have been well spent, and I am confident that they will respond again as in other years.

Donations, large or small, should be sent to the Honorary Treasurer, Royal Medical Benevolent Fund, 1, Balliol House, Manor Fields, Putney, London, S.W.15, marked "Christmas Gifts."

Yours, etc.,

THOS. BARLOW,
President.

Sport

Rugby

GUY'S *v.* MIDDLESEX HOSPITAL.

(*At Honor Oak Park, Saturday, October 7th.*)

(Lost 11–3)

The opening match of the season against Middlesex Hospital went disastrously for Guy's. Not only were we beaten by a goal, a penalty goal and a try to a penalty goal, but at the end there were four serious casualties and we finished with thirteen players on the field.

Despite the casualties, the Hospital failed because several of the players were obviously unfit. This Middlesex XV is a good one, and although they were more skilful in developing their three-quarter play, Guy's proved that they have a set of forwards to match the best.

The game also proved that D. G. Jones will be in the front line of full-backs. Before and after his injury he made no mistake. Fielding the ball cleanly from all angles his long and accurate touch-kicking was a pleasure to watch.

Middlesex led at the interval with a penalty goal by C. McIver, but on the resumption, J. Southgate kicked a grand penalty goal from the touch-line to level the score. R. G. L. Brittain did well to charge down a drop-kick by G. M. Colson, and then Guy's ran into trouble. First, E. W. Graham was carried off with a knee injury, and P. L. Brangwin, who made a welcome return after a season's absence, left with a damaged shoulder. With P. S. Carton-Kelly and D. G. Jones hobbling, the team could not quite hold their opponents, who went further ahead with another penalty by C. McIver and a try by A. M. Whittington, which C. B. McIver converted.

GUY'S *v.* BART.'S.

(*At Honor Oak Park, Saturday, October 14th.*)

(Lost 11–6)

Having to find four players to replace those injured the previous week, an experimental back division was chosen, which included B. M. Gray (full-back), R. G. Nicholson and J. F. Shaw centres, all of whom were having their 1st XV baptism.

One hesitates to criticise, but it was due to faulty passing, bad marking and a lack of penetrative power on the part of the three-quarters that Bart.'s beat us by a goal, a penalty goal and a try to a penalty goal and a try.

The forwards, as usual, played extremely well, being particularly successful in making it a forward game as far as possible, with R. G. L. Brittain an excellent leader, well backed up by A. Batty Shaw, I. H. Hilliam and C. P. Mills, a newcomer who showed good form. Even so, there were signs of slackening, which gives the impression that certain players are not quite fit.

Guy's came within an ace of scoring on a few occasions, and it was gratifying to see R. H. N. Long showing more dash. On one occasion he forced himself over, but knocked the corner flag in the process. If only he could cultivate a swerve with his fine speed and improve his tackling, he may still solve the wing problem.

The scoring opened with R. G. L. Brittain kicking a penalty goal, but this was followed by an error of judgment in our defence which let in Smallwood for Hawkes to convert, who also kicked a penalty.

There was not much to enthuse over during the second half, apart from one grand run by N. K. Macrae-Gibson, but towards the close some exciting forward rushes from end to end led to Smallwood crossing for an unconverted try for Bart.'s, and R. A. Dean went over in the corner for Guy's.

GUY'S *v.* ST. THOMAS' HOSPITAL.

(*Played on Saturday, October 21st* 1944.)

Drawn (0–0).

This game was played on St. Thomas' new ground at Beckenham, and after a hard and evenly contested game, resulted in a draw. Owing to two further casualties in the back division, Dwyer and Nicholson, the outsides were all drawn from the "A" XV, with the exception of N. K. Macrae-Gibson. K, B. Pritchard came in at stand-off; he played well, but he must learn to take the ball on the run and so get the passes out to his centres quickly. J. M. Pugh, playing his first game for the 1st XV, tackled his opposite wing with thoroughness and never did anything wrong.

During the first half Guy's were pressing most of the time. The forwards kept a greasy ball in their opponents' half and the Hospital were unlucky to score. Each member of the pack pulled (and pushed) his weight, but the ubiquitous Brittain and C. P. Mills, a promising new wing forward from St. Peter's, York, were outstanding. After the change-over the game became more open. St. Thomas' showed thrust in the midfield, and Davis, a centre, gave us some anxious moments. But neither side could score and, in spite of a gallant attempt by Pritchard to drop a goal in the final minute, no-side was blown to a drawn game.

The strength of a club lies not only in its 1st XV, but in the activity of its junior sides. On this Saturday the "A" XV beat Reading University, a strong side, and three other XVs were fielded. The secretaries of the Junior XVs, who meet the captain and the secretary each Monday to discuss next week's sides and their performers on the previous Saturday,

are as follows :—"A" XV, P. S. Matthews, Extra A, E. H. Sudell ; "B" XV, P. Chalk, "Nomads," B. W. Harrison.

One hundred and forty men put down their names to play football this season. We cannot give them all a game each week. But if anyone is not getting a game who wants one, he is advised to get in touch with any one of the team secretaries.

Sailing Club

The first season of inter-hospital sailing matches since the war began has come to an end, and has brought with it clouds of glory for Guy's.

Out of the eleven hospitals comprising the United Hospitals' Sailing Club, Guy's has finished the season in second place, being beaten by St. Thomas's Hospital by only two points.

During the months of April to September twenty matches were sailed, each hospital taking part in nine of these.

Guy's secured six firsts and one second place, and on two occasions had a lead of over eight minutes from the second boat.

The following is a list of members who took part in the racing, and the number of matches sailed in :—D. J. Reid, 8 ; G. B. Elphicke, 3 ; D. J. Murch, 2 ; R. Lowein, 1 ; C. M. M. Jenkins, 1 ; J. Wallace, 1.

Guy's supplied several crews to race for the United Hospitals in various fixtures throughout the season, obtaining a large measure of success in so doing.

On June 3rd Elphicke and Reid sailed in the team against Oxford at Hammersmith. The result of the match was a win for the Hospitals, which was very encouraging, because the Dark Blues had beaten the formidable Cambridge team only the week before over the same course.

Two weeks later, in a return match sailed at Oxford, Guy's supplied one-half of the United Hospitals team of six men (P. J. Wright, D. J. Murch, —. Marks). After many thrills (not to mention spills !) Oxford won by a narrow margin.

The big annual event of the London Corinthian Sailing Club, the Kelmscott Cup race, was sailed on September 17th, and proved to be almost entirely a U.H.S.C. affair, it had not previously been won by an outside boat, but the Hospitals carried off first, second and third places !

The membership of the G.H.S.C. stands this year at the record number of thirty-three, being one of the highest since the Club was founded twenty years ago. To mark this event a dinner is being held, details of which will shortly be found on the notice-board.

FIXTURE LIST FOR THE YEAR 1944.

RESULTS.

Hospital.	*Places.* 1st	2nd	3rd	*Total Points.*
St. Thomas's ..	5	2	1	45
Guy's	6	1	—	43
U.C.H. ..	2	4	2	40
Royal Free ..	1	2	3	30
King's Col. ..	—	3	2	28
Middlesex ..	2	—	3	24
Bart.'s	2	1	—	20
London ..	2	1	—	20
Char. Cross & R.D.H. ..	1	1	—	16
Westminster ..	—	—	—	3

Association

At a meeting held at the end of last season it was decided that the club would continue to play in the London University League this season. The clubs playing in the two groups have been re-arranged, so that the eight best clubs by last year's performances will be playing in the same group. thus eliminating the chances of overwhelming victories such as those which Guy's, in particular, scored last season.

Two new fixtures this season are with the R.A.C. O.C.T.U., Sandhurst.

Although the response to an appeal for new members to join the club has not been overwhelming, it is still hoped to run a second XI. Any new students with Soccer experience will be welcomed.

The new club officials are F. R. M. Young (captain) and M. J. L. Sykes (secretary).

GUY'S *v.* BEXLEYHEATH SPORTS CLUB.

(*Played at H.O.P. on September 30th*, 1944.)

Drew 1–1.

Fairly even play for the first twenty minutes ended by Bexleyheath being awarded a penalty from which they scored. From then until half-time Bexleyheath had most of the play, Guy's being slower on to the ball and too light in tackling. In the second half Murphy moved up into the forward line, which soon altered the run of the play, Guy's attacking hard. Eventually Trist neatly dodged between a covering back and the goalkeeper and pushed the ball into the net. No further goals were scored in spite of pressure from both sides. The Guy's defence was sound, Busbridge playing well in goal.

Team.—I. L. Busbridge, N. T. McNeil, F. R. M. Young (captain), J. A. Stewart, E. G. Murphy, C. S. Mathews, A. A. Collis, M. J. L. Sykes, R. A. C. Dove, A. E. Trist, R. Owen.

GUY'S *v.* NORSEMEN.

(*Played at H.O.P. on October 7th*, 1944.)

Lost 5—4.

With only five of last season's players being able to turn out, Guy's gave a good account of themselves against a strong side. At half-time the score was 2–3, Norsemen leading, Guy's goals being scored by Sykes and Munro.

The Norsemen soon increased their lead, bringing it to 5–2 before Guy's rallied adding two more goals, both scored by Trist. Further strong attacks by Guy's were unavailing.

The side showed a distinct improvement on the previous week's play.

Team.—I. L. Busbridge, A. W. R. Williamson, C. S. Mathews (captain), J. A. Stewart, H. R. C. Riches, R. A. C. Dove, I. A. N. Munro, M. J. L. Sykes, A. E. Trist, W. A. Evans, R. Owen.

GUY'S *v.* LONDON HOSPITAL.

This match was played at Hale End on Saturday, October 21st, 1944, and resulted in a win to London Hospital by two goals to one.

Guy's won the toss and played with the wind behind them and the slope of the ground in their favour. We were unfortunate in having a very depleted team owing to illness and injuries. London first scored from a penalty goal and soon followed this with a very well placed shot from their inside right.

Guy's rallied and pressed hard for the rest of the game ; the forwards, however, never managed to play well together and finish their movements. Ten minutes from time Guy's scored their only goal through Dove. Guy's kept up the attack with renewed vigour, but were unable to equalise.

Team.—I. L. Busbridge, A. W. R. Williamson, F. R. M. Young (captain), E. M. Newton, H. R. Riches, C. S. Matthews, I. A. H. Munro, R. A. C. Dove, A. E. Trist, A. R. Merill, P. E. Owen.

Hospital Information, etc.

Notices

NUFFIELD HOUSE

Applications are invited from qualified medical practitioners unfit for service with H.M. Forces, for the post of Resident Medical Officer to Nuffield House (Pay Bed Block), Guy's Hospital, S.E.1. This post is graded B 2, and carries a salary at the rate of £250 per annum with full residential emoluments. The appointment will be for a period of six months in the first instance, but this will be extended for a suitable applicant.

Applications should be sent to the Secretary of Nuffield House, Counting House, Guy's Hospital, not later than December 11th, 1944.

DIETETICS—WINTER TERM, 1944.

Dr. A. C. Hampson will give a second lecture on Dietetics in the Physiological Theatre on Friday, December 8th, at 4 p.m.

Pass List

ROYAL COLLEGE OF PHYSICIANS.

October, 1944.

M.R.C.P.

F. K. Lau, M.B.(Camb.),
R. I. McCallum, M.B.(Lond.),
J. R. Trounce, M.B.(Lond.).

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FINAL EXAMINATION.

October, 1944.

PART I.—Surgery.

D. A. Barr	M. C. Hudson
S. G. Beaton	G. A. Morrant
J. R. Burt	D. J. Reid
P. C. S. Campion	J. D. Rumble
J. E. Dyke	P. S. Sutton
G. Henry	J. E. C. Weddup
I. H. Hilliam	P. J. R. Whyte

PART II.—Dental Surgery.

C. G. Bason	P. J. Hill
S. G. Beaton	J. R. James
K. H. Brown	J. B. Kyle
J. G. Davimes	P. T. Parr
H. E. P. Grabaskey	D. J. Rayner
J. D. Green	I. T. M. St. George
P. C. Hanley	J. S. Spencer
E. K. Harris	R. D. W. Stileman
F. B. Hickman	H. I. Tozer

Papers by Guy's Men

Lane-Roberts, C. S. Problem of Subfertility. *Post-Grad. Med. J.*, 1944, **20**, 232.

Law, Frank W. Ophthalmology. *Practitioner*, 1944, **153**, 233.

Clarkson, P., and Another. Observations on Prosthesis. Provided by U.S. Army Department of Medical and Museum Act for a Maxillo-Facial Surgical Unit. *Brit. Dent. J.*, 1944, **77**, 168.

Hancock, J. G. Technique. *Ibid.*, 169.

Colbeck, J. C., and Another. Dried Rabbit Plasma for the Staphylococcus Coagulase Test. *Brit. Med. J.*, 1944, ii, 471.

Douthwaite, A. H. Blood and Iron. *Clin. J.*, 1944, **73**, 169.

Campbell, A. M. G. Hereditary Familial Telangiectasis with Epistaxis and Migraine. *Lancet*, 1944, ii, 502.

Wills, Lancelot. Nodular Leprosy. *Proc. Roy. Soc. Med.*, 1944, **37**, 644 (Sect. Dermat.).

Mollison, W. M. A case of Sarcoma of the Ethmoid. *J. Laryngol. Otol.*, 1944, **59**, 62.

Gillespie, R. D. Psychological Medicine (Advances in Treatment). *Practitioner*, 1944, **153**, 297.

Johnstone, D. F. Mistaken Diagnoses in Common Infectious Fevers. *Brit. Med. J.*, 1944, ii, 555.

Edwards, L. R. L. An unusual case of Meningococcal Meningitis. *Brit. Med. J.*, 1944, ii, 563.

Change of Address

H. Bloom, Capt., R.A.M.C., 49 F.D.S. B.L.A.

R. Jarman, D.S.C., 36, Queen Anne Street, W.1.

L. R. McLaren, Surg.-Lieut., R.N.V.R., H.M.S. *Raider*, c/o G.P.O., London.

W. A. Porter, Ft.-Lieut. (135279), 3 Repair Unit, R.A.F., India.

F. J. R. Stoneham, Squad.-Ldr., R.A.F., 6, Calverley Park Gardens, Tunbridge Wells.

S. S. Zuzman, Lieut.-Col., R.A.M.C., 84, Harley Street, W.1.

The Services

Awards

Efficiency Decoration of the Territorial Army, Major J. C. C. Howe, R.A.M.C.

Mentioned in Dispatches.

Major (temp. Lt.-Col.) T. E. A. Carr, T.D., R.A.M.C.

Killed in Action

J. T. Doyle.

Missing now Presumed Killed

Surg.-Lt. P. S. Cuthbertson.

Marriages

HUMPHRIS—WATSON.—On October 21st, 1944, at Holy Trinity, Lee, David Humphris, Lieut., A.D. Corps, to Betty Watson, of Lewisham.

STONEHAM—WALKER.—On October 14th, 1944, at the Savoy Chapel, London, Frederick James Russell Stoneham, Squad.-Ldr., to Pauline Elaine Walker, S.O.

Births

WHITWORTH.—On October 30th, 1944, at "Four Winds," Dalehouse Lane, Kenilworth, to Margaret, wife of Kenneth W. Whitworth—a son (George Arthur).

Deaths

KEMP.—On October 23rd, 1944, at 33, Potter Street, Worksop, George Lajus, M.D.(Lond.) aged eighty, the beloved husband of Beatrice May.

NEWLAND-PEDLEY.—On May 4th, 1944, in North Italy, Frederick Newland-Pedley, F.R.C.S., L.D.S., of 22, Willow Road, London, N.W.3.

EDS {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

THE time is at hand when we shall have to decide on our own personal policies with regard to the future of medical practice in this country. Some are in favour of the White Paper, a greater number are against it, and a few have read it. Considering this, the rigid and unequivocal views held on it are amazing and the disinclination to reach a compromise on the subject seems unreasonable. Could we not arrange to steer a course between the Scylla of the diehard reactionaries and the Charybdis of the idealogical but unpractical reformers? Such a course has recently come to our notice, and we would like to submit it for what it is worth.

The scheme is that adopted by the New Zealand Government in 1941 under the Social Security Act, and its advantages have been stressed by the County Practitioners' Group in a recent pamphlet. They emphasise that the scheme provides a complete medical service for all on a democratic basis; it protects the freedom of the doctor, preserves private practice and the voluntary hospital system, and, in addition, costs less than the White Paper proposals. In this way, they claim, the aim of the White Paper is upheld, but the method employed in furthering this aim is free from totalitarian influences.

Briefly, the scheme is comprised of five benefits—Hospital, Medical, Maternity, Pharmaceutical and Supplementary. Under hospital benefits the Government pay hospital boards 9*s.* per occupied bed per day, a total of three guineas a week. In addition, the out-patient services are subsidised at a rate of 60 per cent. of their total expenditure. Medical benefits are largely covered by the refund and capitation systems; in the former a general practitioner is paid at the rate of 7*s.* 6*d.* for a consultation or visit with extra considerations for night work and mileage travelled to the patient's home. The patient pays the doctor the entire fee and then claims for a refund from the Department of Health, having been supplied with a certificate by the doctor; this system is claimed to work very well in practice. Maternity benefits are five guineas to the doctor for ante-natal care and attendance at the confinement and similar benefits to maternity hospitals and obstetric nurses. Pharmaceutical benefits are paid in respect of prescriptions issued by doctors; and supplementary benefits cover X-ray diagnostic services, physiotherapy, and so on.

Attractive and efficient as this scheme might appear to be on paper, practical experience has shown up its weaknesses, and the general practitioners of New Zealand have opposed it on several points, the main bone of contention being that a fixed payment for services rendered irrespective of their nature and quality is both unfair and liable to lead to shoddy workmanship and unnecessary calls upon the doctor's time. The remedy suggested for this defect is that the doctor shall charge his usual fee and the patient claim refund up to the prescribed amount. Although the bogies of electioneering party politics, totalitarianism and the like have been aroused to confuse the true issue, the situation begins to resemble a mercenary squabble not altogether in accordance with the dignity of the profession.

AT a meeting of the Statutory Court of Governors, Viscount Goschen resigned from the office of President of this Hospital. Viscount Goschen has held this position for eight years, and it is with regret that we see him leave us. In his place we would like to welcome Viscount Nuffield, who was unanimously elected as his successor by the Court of Governors. Lord Nuffield's position as Treasurer of the Hospital has been filled by Mr. J. E. Humphery, who has for many years been a Governor and Chairman of the House Committee.

MANY of our teachers who have recently left us to join the Services were back with us this week. Dr. E. R. Boland was spending a few days of his leave here, as were Drs. French and Tillman. Dr. de Navasquez and Mr. Glover are also back in this country and have been seen at the Hospital recently.

WE are sure that our readers will join with us in congratulating Mr. T. B. Layton on his recent appointment—Director of Medical Services, Sicily. We gather that he will be leaving to take it up early in the new year.

IN the recent Special Number of the *Gazette*, the Students' Union was named as one of the Societies unconnected with the Clubs' Union whereas it is in fact an affiliated member.

So-Called "Atypical Pneumonia"

BY "UNCLE HARRY."

I USE the term "so-called" because I am not at all satisfied that this disease is, in its uncomplicated form, a true pneumonia. My reasons for this will be given later. Let me describe what in my own experience is a typical case.

The patient calls you in and says that he thinks he has got influenza. He says it came on quite suddenly.

He says his throat is sore and that he aches all over, especially in his back. This aching may be much more severe than that met with in ordinary influenza and is rather like that of dengue. There is a feeling of great malaise and fatigue with severe headache. He complains of feeling very chilly all over, but there is nothing like a typical rigor. From time to time he has profuse sweats and feels feverish. In what I call an uncomplicated case there is no cough and no sputum. The temperature in the morning may be 99 deg. to 100 deg., to 101 deg. or 102 deg. in the evening and, apart from his complaints of aches, malaise and slight sore throat, he does not look ill. His respiration is 16 to 18, and his pulse 80 to 90.

In the course of a routine examination you are surprised to find one side of his chest completely dull, yet the breath sounds are quite well heard and only little, if any, fainter than on the other side; and there are no abnormal or adventitious sounds on either side. There is no cough and no sputum.

In answer to questions the patient says he has no pain in his chest, but that it feels a little "tighter," especially on the dull side, but nothing suggesting the pain of pleurisy. No rub can be heard at this stage, although later, if there is going to be effusion, a soft coarse rub may appear lasting only a day or so.

The remarkable dullness makes one suspicious, so the chest is X-rayed as early as possible; say, within forty-eight hours from the onset of the illness. The result is likely to be surprising and, if you have had no previous experience of the disease, to produce feelings of amazement. Amazement that such an extensive lesion can exist in the chest without any dyspnœa, cyanosis, cough or sputum.

For example, if the right side of the chest is the dull side, you will see a hazy, soft-looking infiltration extending in rather a fan-like manner from the hilum of the lung towards the periphery, especially of the lower or lower and middle lobes. There may be some pleuritic effusion, but not necessarily. If there is, it may be quite small in quantity or so considerable as to reach the sulcus between the middle and upper lobes. You may fear the possibility of an empyema, but if you do a daily white cell count you will probably find it about 8,000, and this may decrease in the course of a few days to about 5,000 or so. You will probably repeat this to make absolutely certain that it is correct, scarcely able to believe your own results.

So you think to yourself that with such a W.B.C. count there is no pus there up to the present.

Then you may be strongly tempted to put in a needle and draw off some of the fluid. If you do, all you will get will be some bacteriologically sterile, rather blood-stained fluid; but my advice to you is to do nothing of the sort. You are dealing

with a virus infection and, in any case with a low W.B.C. count, suppuration should not normally be expected. Even with very extensive effusion I have refrained from putting a needle in—(*a*) because there was no displacement of the heart, and (*b*) because there was no dyspnœa and no cyanosis. To be perfectly honest I must add—(*c*) because I am a retired Air Force officer and have a whole-hearted fear of gremlins which can hide quite easily, even in a sterile needle !

To describe the most outstanding and striking feature of the disease, I can best do this by inverting the old medical *cliché* frequently applied to malingerers. It is the "multiplicity of lesion and the paucity of symptom." This is best demonstrated radiologically ; and it will usually be found that the other lung has not escaped. There may be patches of what the radiologist describes as "collapse" or "atelectasis," or even a considerable part of a lobe—*e.g.*, the lower—may be involved. It is remarkable to look at the film showing such widespread involvement and look at the patient with no cough, no sputum, no dyspnœa, no cyanosis, and apparently very little the matter with him except that he runs a morning temperature of 99 deg. to 100 deg. and an evening one of 101 deg. to 102 deg., and complains of occasional profuse sweats and coldness, especially of his legs and feet, which really *are* cold in spite of hot-water bottles.

If you made an early diagnosis of influenza and put him on salicylates the sweats may be drenching, and the sooner you take him off them the better.

The importance of frequent radiological examination cannot be emphasised too strongly. At least two films a week should be taken, one A.P. and one lateral. More can be learned from them as to the patient's progress than from the most careful clinical examination, and nothing impresses the mind of the physician more than examination and comparison of the completed set of films of a recovered patient.

So the diseases progresses. It may be completely resolved within a fortnight, especially if the area involved has been comparatively small ; or it may go on as long as thirty days or even longer. Cases have been known to persist for a year or more. Whenever I hear of a case of "unresolved pneumonia" six months or more after the initial attack I always wonder whether it may not be "so-called" atypical pneumonia.

When it has been progressing for more than two or three weeks the patient is liable to become very depressed and it is important to reassure him.

What is the pathology of the condition ? There is pretty strong evidence that it is due to a virus infection.* A positive complement-fixation test has been obtained from the serum of some of these patients with the virus of psittacosis, although there is no clinical resemblance to this disease. Also the virus of ornithosis. American workers have implicated viruses allied to lymphogranuloma venereum, lymphocytic choriomeningitis, influenza, chicken-pox and small-pox. The latest virus to be incriminated is that of vaccinia, which is hardly surprising having regard to its relationship to small-pox. I myself strongly suspect the virus of mumps.

The probability—almost the certainty—is that the disease may be caused by more than one virus and that its clinical characters may vary accordingly.

The mortality of the disease as seen in this country is practically *nil*, therefore there are few opportunities for necropsy. Dr. David Haler, who recently had occasion to perform one, tells me that he was struck by the dryness of the lungs, which he likens to "a dry sponge."

Treatment.—Being a virus infection it is obviously useless to use any of the sulphonamides. In the U.S.A. Correll and Cowan† have used Roentgen therapy immediately a radiological diagnosis has been made. They devised a standard dosage of 112 "r" units over the involved area, repeated in twenty-four hours if the clinical response was not satisfactory. They found that it was never necessary to give more than two treatments and that their cases showed no local or constitutional reaction and that no skin changes were noted.

In cases with effusion, to which I have given a mixture of Liq. Hydrarg. perchlor. ʒi with pot. iodid. gr. 5 to 10, I have found the effusion disappear quickly and, whether *post hoc* or *propter hoc*, a marked improvement progressing to complete recovery, and think this is worth a further trial. I have also used inhalations of O_2+CO_2, beginning with one minute every hour and gradually increasing to five minutes. Patients say they get great relief from this. Sometimes they complain of pain on the affected side with the longer periods, when I reduce it until they can tolerate the increased quantity

again. I have not used a "blow-bottle," so that strain on the compensatory emphysema of the less affected lung could be avoided.

Nomenclature.—The American official nomenclature of the disease is "atypical pneumonia of unknown etiology," but it has also been called "pneumonia migrans," "virus pneumonia," "virus bronchopneumonia" and "pneumonitis." With absence of involvement of air-vesicles, no sputum and no cough, it seems to me that the prefix "pneu-" is hardly justified. In the absence of histological proof to the contrary, my belief is that the interstitial tissue is chiefly affected rather than the air cells, and I prefer the name "interstitial pulmonitis."

* Reimann, Havens and Price. *Archiv. Int. Med.* 70, 513–522, October, 1942.

† *U.S.N. Med. Bulletin.* Vol. XLI. No. 4. 980. July, 1943.

Royal College of Nursing

NURSING RECONSTRUCTION COMMITTEE—THE HORDER REPORT.

(Sections II and III).

Reviewed by E. E. P. MacMANUS, O.B.E.

In the nursing profession the term "Athlone Report" is well known; it refers to the Inter-Departmental Committee on Nursing set up by the Government a few years ago under the chairmanship of Lord Athlone, to inquire into conditions in the nursing profession and to make recommendations. Its interim report was published in December, 1938; it covered a wide field and received an instant welcome by the nursing profession. The threatening war clouds, so evident early in 1939, claimed the nation's attention to international matters and the findings of the Athlone Report could not be implemented—nor even fully examined by hospital boards of management or other employing authorities. In spite of this, a certain measure of reform took place in many hospitals, partly as a result of the Report and partly owing to the fresh contacts and exchange of ideas brought about by the linking up of hospitals of different authorities under the Ministry of Health's Emergency Medical Service Scheme.

As the war went on it became clear that national measures of internal reform could not stand still. The Nursing Services again came under review by the Government, and in November, 1941, the Minister of Health, Mr. Ernest Brown, set up a Committee under the chairmanship of Lord Rushcliffe, whose terms of reference were:—

> "To draw up, as soon as possible, agreed scales of salaries and emoluments for State-registered Nurses employed in England and Wales in hospitals and in the public health services, including the service of district nursing, and for student nurses in hospitals approved as training schools by the General Nursing Council for England and Wales."

These terms were subsequently widened to include tuberculosis nurses and assistant nurses.

This, in effect, carried on and extended the general recommendation of the Athlone Report that nurses' salaries and emoluments must be improved and standardised. The Rushcliffe report also made a few valuable recommendations regarding hours of work and terms and conditions of service.

However, by far the largest section of the Athlone Report's findings were left untouched.

At this point the Royal College of Nursing stepped in and, with the Minister of Health's full knowledge and approval, set up the Nursing Reconstruction Committee, under the chairmanship of Lord Horder. The main committee was divided into four sub-committees, each to examine its own problem.

Section 1 of the Horder Report—the Assistant Nurse—was presented to the Minister in September, 1942, and its findings were largely embodied by him in the New Nurses' Act, April, 1943, which, among other things, laid upon the General Nursing Council the duty of establishing a State Roll for Assistant Nurses, and prescribing for them a syllabus of two years' teaching. Existing nurses of good report and long standing, but no organised training, or nurses who have taken some recognised nursing course of not less than two years can be placed on this roll during a period of grace. It is to be noted that the minimum course of training for a general trained State regis-

tered nurse is three years. Assistant nurses are a valuable category of nurse and fill a very real need in the health services of the country, but in the past their reputation has suffered from the lack of a standard of knowledge and the inclusion of many unsuitable people among their ranks.

The ensuing fifteen months were spent in preparing the next two sections.—Section II, Education and Training; Section III, Recruitment. The bearing of these two subjects upon each other was so close that they were published together.

The terms of reference in each case were as follows :—

"*Education and Training.*—To consider how best to model nursing education so as to ensure the preservation of the highest professional standards; to consider present defects in this respect; to suggest remedies with special reference to the educational functions of the general Nursing Councils, and the adequacy or otherwise of the system of State Registration now in force; and to make recommendations for further post-certificate education."

"*Recruitment.*—To survey the present and future demand for a supply of Nurses; to examine present deterrents to recruitment; to suggest ways of making the profession more attractive to women of ability; and to advise on methods of recruitment and any *germane matters.*"

As the Committee proceeded in its work it became more and more convinced that, given a liberal outlook and a carefully planned curriculum, the training of nurses in this country could be developed into one of the great national educational movements for women—a view which members of the teaching profession, and particularly science teachers, are beginning to share. Unfortunately, the training of nurses is still too closely linked with what should be regarded fundamentally as an entirely separate problem—the provision of nursing care for the patient. Again, the education and training of the nurse, despite minor improvements, is still too haphazard; the public pays its automatic tribute to a service maintained under handicaps with which no true educational movement should be faced.

The Horder Report Sections II and III can be obtained from H.M. Stationery Office, the Royal College of Nursing, 1, Henrietta Place, Cavendish Square, W.1, and at the Matron's Office, Guy's Hospital, It is put together in an easy narrative style and makes interesting reading. Members of the Medical and Nursing Professions who are interested in the progress of education in the two professions as they go forward, hand in hand, would find a copy of this Report useful for reference during the years of reconstruction in the health services that lie ahead of us.

Several very important aspects of the process of making a trained nurse were examined by the sub-committee on education and training; in each case the argument is elaborated in the main report. Some of the more important recommendations are given here.

1. *The Student Status of the Nurse.*—"While the Student Nurse must be regarded as a component part of the hospital personnel in order that she cultivate a sense of responsibility, her status as a STUDENT nurse should be fully recognised by the trained nursing staff, the medical staff and the governing body of the hospital and her work should be regulated accordingly." In this connection the Committee recommends the introduction of an *improved ratio of nurses to patients.* It emphasises the fact that nursing is not merely an item in the nation's medical service, but a profession parallel to that of medicine, occupying an appointed and increasingly important place in the national plan for health.

The Educational Approach.—Though the nurse's training is, to a certain extent, an apprenticeship, there must be a much larger proportion, than at present, of permanent trained staff to supervise and explain her work, and sufficient ancillary staff to perform certain normal routine duties. Those responsible for the nurse's education must first plan the syllabus and practical work in her interests as a student and then take measures to secure the appropriate hospital experience."

The question of finance and the case for State-aid is fully discussed :—

"**Not until the income of the training school is independent of the hospital to which it is attached can the nurse attain full student status.** There is only one endowed training school in the country to-day, and even that endowment is insufficient for its needs.

"**Apart from individual hospital finance there must be funds for inspection, to see that the provisions outlined above are carried out.** *Much attention has recently been focussed on the* work of the Nurses' Salaries Committees set up by the Minister of Health and the Department of Health for Scotland under the chairmanship of Lord Rushcliffe and Professor Taylor respectively. These Committees were instrumental in putting into force one of the financial recommendations of the Athlone amd Alness Committees, *i.e.*, that hospitals receive financial aid towards the cost of nurses' salaries. The Committees' second (complementary) recom-

mendation is apt to be overlooked, namely, that hospitals receive aid towards the cost of nursing education. Clearly, if the training school is to conform to these standards, outworn financial methods no longer meet the needs, and the Committee is of the opinion that the time has now come when all nurse training schools should receive financial aid from the Treasury—possibly on the lines of the University Grants Commission—irrespective of whether they are voluntary or municipal. The primary responsibility for the health of the nation rests with the State, and the task of educating the nation's nurses is now beyond local resources.

The State should implement recommendation 3 (a) *of the Interim Report of the Athlone Committee: that grants be given 'from national funds to all recognised training hospitals in respect of the national work done in the training of nurses.'*

"State aid will naturally imply a measure of State control, which should take the form of regular inspection and supervision by the statutory nursing body, the General Nursing Council.

"The Committee's experience leads it to express the opinion that no hospital policy should be influenced by party politics, and the Committee emphasises that the control of nursing education should always be vested in a central body.

"**The Committee views with concern the increasing tendency to entice student nurses into the profession with liberal remuneration during their training. Unless this tendency is ultimately reversed the relationship between the hospital and the student nurse will remain what it largely is to-day, that of employer and employee. The nurse's training must not be regarded as employment, but as training for a profession.** In the field of medicine, while more and more students are receiving financial help to enable them to qualify, those who can pay for their training continue to do so. In the same way, the proposed schemes for the reform of our national education do not envisage the abolition of all fees for continued education, but the gradual extension of opportunities for every educable citizen. **The Committee therefore supports the principle that, when possible, the student should pay for her training, but that no good potential nurse should be debarred from training through lack of money.**

"The expenses of such students should be met by liberal maintenance grants and scholarships from national and other funds, as is the case in other professions, and also in many nursing schools in Canada and the United States, in Sweden and in Czechoslovakia. Student nurses themselves, to judge from opinions sent in by the Student Nurses' Association of the Royal College of Nursing, fully realise that high pay in student days is incompatible with student status, and the great majority wisely attach more value to their status as students."

2. *The Need for a Wider Basic Training.*—

"The chief object of training in the past has been to provide a sound knowledge of medical and surgical nursing; but, in view of the recent extension of nursing into fields of social medicine, a wider basis is now required. To meet this need **the Committee recommends a more elastic programme covering a period of four years, to include an introduction to preventive and social medicine, short, varying periods of specialist experience in obstetric nursing and in branches which may not hitherto have been covered, such as fever, tuberculosis and mental nursing, and an elective six months in a specialty in the last year.**"

After fully considering the problems of hospitals of many different sizes and situations, which are endeavouring to train nurses at the present time, the Report recommends:—

"That nurse training units should be either: (1) large parent hospitals linked with one or more subsidiary hospitals for training in certain specialities; or (2) groups of smaller hospitals which would combine to provide the complete basic training."

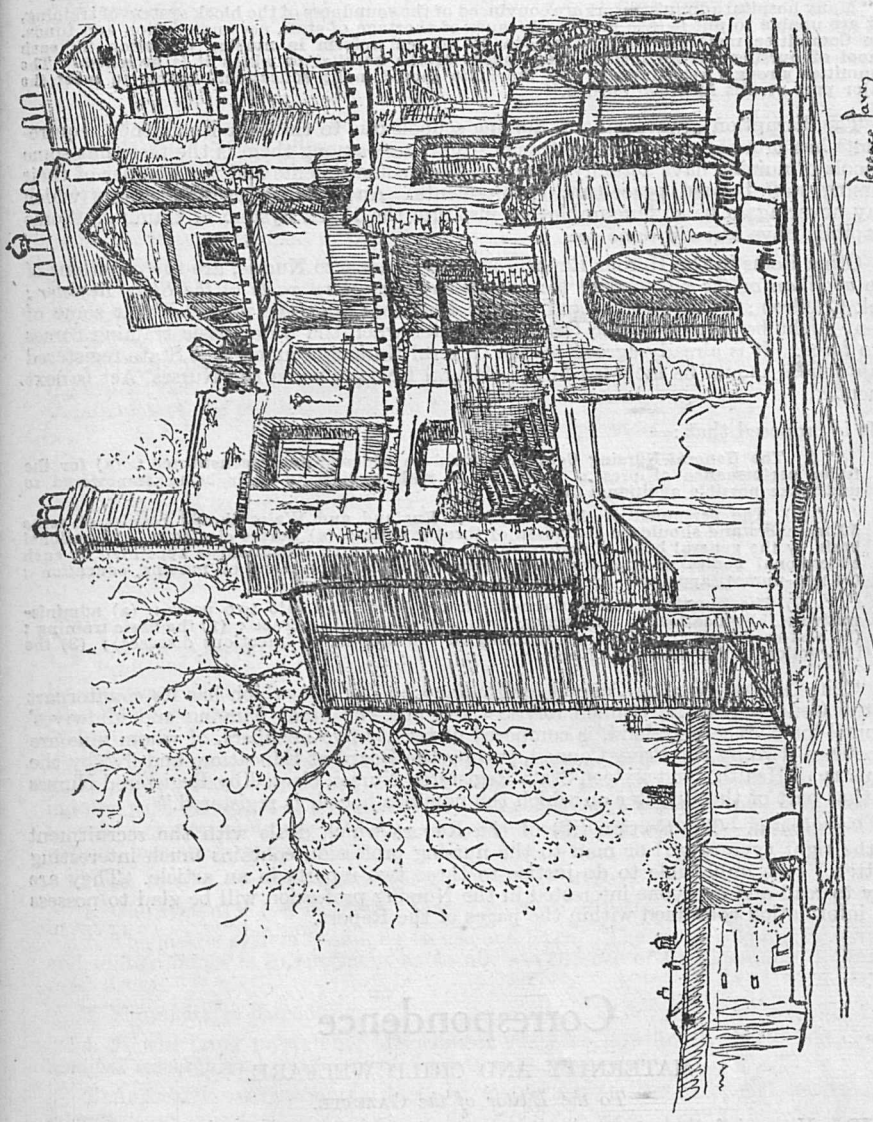
3. *The Block System.*—Persons interested in the education of nurses are generally agreed that the present system is unsatisfactory and outworn. Student nurses—day staff and night staff—carry on all their theoretical study concurrently with their Ward duties—attending lectures and classes at unsuitable hours either when they should be "off duty" getting fresh air and recreation or late in the evening when they are too tired to take in what is being taught.

If the lectures and classes are arranged in "on duty" hours, as recommended in the Government's Rushcliffe Report, the Ward Sisters may be left with a shortage of nurses and find it difficult to give the necessary nursing care to the patients.

The Horder Report makes the following comment and recommendation:—

"The most frequent criticism levelled at the wider basic training is that it is overloaded. The Committee hopes to show that, if the student's timetable is planned in her interests, and the hospital carries an adequate number of trained staff and domestics, such a scheme is not only possible but capable of universal adoption. The Committee has examined a number of suggested schemes advocating a wider basic training, and has been encouraged to find that no one who has given this training serious thought believes it possible of achievement except under some modification of the 'block' system. Under this system the student is relieved of her hospital duties for varying periods, during which she receives the greater proportion of her theoretical training."

"The Committee advocates the 'block' system of training, an example of which is reproduced in detail in Appendix IV, as embodying the essential features of a syllabus planned in the nurse's interests and making the most economical use of the time at her disposal. A considerable part of the student's theoretical work is concentrated in four blocks. The example quoted allows for a twelve-week block in the preliminary training school, two seven-week blocks in the first and second year, and a two-week block in the third year. The fourth year is elastic, and is spent in concentrated and responsible practical work and in opportunities for specialisation. During the block periods the students are free from nursing responsibilities,



GUY'S 1944—A STUDY

and are regarded purely as students; during their practical work they are an integral part of the hospital staff.

"Any general adoption of the block system presupposes—(i) a State subsidy; (ii) the co-ordination of the hospital system; (iii) an increase of a sixth to an eighth in the nursing staff. The chief aims of the system are—(*a*) the avoidance of strain; (*b*) the linking of theory with practice; (*c*) more careful supervision and training in practical techniques; (*d*) a higher ultimate standard of work.

"Many hospital administrators are convinced of the soundness of the block system of training, but are unable to put it into practice because of shortage of staff, accommodation and funds. **The Committee maintains that there can be no real reform in nursing education till each school of nursing has an income independent of the hospital to which it is attached. The Committee strongly recommends that the State should make educational grants to meet the major part of this financial burden.**"

The disruption of medical and nursing schools due to the War Emergency requirements has brought about many strange situations—among them is the fact that some schools of nursing have actually increased their commitments and the number of their nursing staff beyond peace-time requirements. An opportunity now occurs which may never again be so favourable—to institute the Block System of training. Some hospitals have already done so.

Other items in the Horder Report, of great interest to Nurses, are the questions of the *abolition or the retention of the present supplementary parts of the State Register;* Sick Children; Fever; Male and Mental Register; and the proposal that some of them might be merged in the General Register when the wider basic training comes into force. It is already agreed by the General Nursing Council that State registered male nurses should be included in the General Register when the Nurses' Act is next amended.

It is proposed that:—

"(i) The General Nursing Councils should be widened and reconstituted: (a) for the fuller performance of present duties; (b) with a view to their being empowered to undertake possible additional duties.

"(ii) The personnel of the Council for England and Wales should consist of some 50 members and should be composed of three groups: (a) nurses elected on a functional basis by the general body of registered nurses; (b) nurse educationists appointed by such educational bodies as are primarily engaged in the promotion of nursing education; (c) non-nurses, appointed by Government and public bodies.

"(iii) The functions of the Councils should be divided into two parts: (a) administrative; (b) educational. The educational section should embrace: (1) the basic training; (2) post-certificate training (*e.g.*, training in the nursing of infectious diseases); (3) the instruction of the Assistant Nurse.

"The General Nursing Council for England and Wales, which has its counterpart in the General Nursing Council for Scotland and the Joint Nursing and Midwives' Council for Northern Ireland, is composed of twenty-five members, of whom nine are appointed (two by the Privy Council, two by the Board of Education, and five by the Ministry of Health), and sixteen State Registered Nurses, elected by Registered Nurses on that part of the Register on which the nominee herself is registered."

Recruitment.—The Section (iii) of the Report which deals with the recruitment of the right type of girl or man to the nursing profession contains much interesting matter. It is impossible to do justice to these two reports in an article. They are easy to read and everyone interested in the Nursing profession will be glad to possess the information contained within the pages of the Report.

Correspondence

MATERNITY AND CHILD WELFARE.

To the Editor of the GAZETTE.

SIR,—You ask for comments on the proposed plans of the new Hospital. I hope it will be not so very long before the building is begun and not too many years before it is completed.

May I, as a nurse interested in maternity and child welfare work, hope also that room will be found to provide accommodation for women medical students? I find, after some years' work of this kind that there is a definite need for women doctors to work among mothers and babies, and in the school medical service. Guy's has always

been a pioneer. Let us hope that the Hospital will open her doors to women medical students and give women the chance to become Guy's doctors as well as Guy's nurses.

In the previous correspondence in the *Gazette* some months ago on this subject, the only concrete objection seemed to me to be the lack of accommodation. Now, with the proposed extension, that can be remedied.

Yours, etc.,

Windsor, Berks. M. E. C.

CATERING AT GUY'S.

To the Editor of the GAZETTE.

SIR,—For many years as a student at Guy's I was a regular patron of the restaurant in the College. I was told that the use of the restaurant was a privilege of membership of the Clubs' Union.

Before the War an excellent lunch (table d'hôte) was to be obtained for one shilling and fourpence; the equivalent now costs, approximately, double that amount. Although the cost of food in public restaurants has risen above pre-war levels, it has not increased by 100 per cent. At several London medical schools it is possible to lunch well for a few pence over a shilling. Why is there this discrepancy?

Service in the College is slow—because of staff difficulties, and now one has to queue outside on the steps.

The three popular catering companies have overcome the shortage of staff by instituting self-service. Would this not be possible at Guy's, or would it be incompatible with the dignity of the medical profession?

Yours, etc.

P. F. PEARSON.

P.S.—Credit is due to the employees of the College Catering Company, who have worked so hard to feed us under very difficult circumstances.

METRIC SYSTEM IN PRESCRIBING.

To the Editor of the GAZETTE.

SIR,—Those of us who have followed the correspondence in the *British Medical Journal* of recent weeks on the use of the metric system in prescribing, initiated by Professor Nixon and supported by Dr. A. H. Douthwaite and others, cannot but be convinced that the arguments for its total adoption are immeasurably stronger than those in favour of retaining the present confusing and illogical apothecaries' system.

The use of two systems, as at present, indiscriminately, is confusing and not without its dangers. The anæsthetist premedicates with atropine and morphia in grains, induces with pentothal in grammes, and then continues with ether measured in ounces (apothecary's or avoirdupois ounces—who knows?), blown into the lungs by gas and oxygen measured metrically!

Here, briefly, are the advantages of the metric system:—

1. One system is less confusing than a mixture of two.

2. The metric system is simpler to use and learn. The range covered by grammes and milligrammes is so enormous as to obviate the use of fractions and decimals in most drugs.

3. Simplicity in dispensing.

4. It will bring prescribing and clinical medicine into line with the biochemical, medical research and pathological departments.

5. As nearly every country uses the metric system, international medicine will benefit.

The Lancet, 118 years ago, anticipated the adoption of the metric system "in a few years." In 1914 the B.P. gave the metric dosage in addition to the apothecary's dosage in the expectation that the former would be universally adopted "in the near future." Why the deplorable delay and inertia? The demand must come from the medical schools and the prescribers, and the examining authorities and manufacturers will sooner or later have to fall in line, unless we have to wait another 118 years until

they decide to initiate the change. Now, when so many changes are about to be made in the profession, is the time to act. I therefore appeal to all Guy's men to use the metric system exclusively, adding in brackets, where necessary, the equivalent apothecaries' dose, until the metric system be universally adopted.

It is my wish to see Guy's, which has led the field so often before, once again show the way to other less progressive institutions, and be the first hospital to discard the outworn apothecary's system of measure and bring about the long-needed change to the metric system.

Yours, etc.,

P. BRYANT.

Orpington Hospital, Sector 10.

Reviews

The Practice of Nursing. By HILDA GRATION. Published by Faber & Faber, Ltd *Price* 12*s.* 6*d.*

IN those long ago days when craftsmen took a pride in the work of their hands and mass production furniture and utensils were unknown, our forbears recognised and appreciated style and design and finish—this lovely shape, that beautiful piece of wood, this perfect polish.

There will always be three ways of doing things—well, badly, or perfectly. Miss Hilda Gration, in her book "The Practice of Nursing," which might, indeed, be called "Design for Nursing," has led us back to a recognition of craftsmanship. The twin arts of healing and of nursing call forth the best that our brain and fingers can give; mass production has no place here. Progress is inevitable, but "progress" is a word often misapplied, and the nursing craftsman must decide whether or no good organisation has simplified a task, or whether the desire to save a few minutes or to cut down the number of staff employed has taken the bloom off good work, disheartening the good worker, debasing the craft and ill-serving the patient. In the pithy foreword by Sir Herbert Eason, late Superintendent of Guy's Hospital, and in the preface the keynote of this book is to be found. It does not claim to be a comprehensive guide to the whole nursing field; it places the patient in the centre of the picture, shows the right method of approach, and describes in detail various nursing techniques. There are excellent illustrations. "The Practice of Nursing," with its simple and explicit directions and explanations, will fill a well-marked gap in nurses' libraries, and it should be of value, too, to qualified medical men who wish, not only to order the right nursing treatment, but, in addition, to be able to explain in detail to some new and untrained orderly or helper how it should be done. Throughout the book Miss Gration stresses the need for finish in the performance of all the procedures she describes if the patient is to be truly served. It is clearly a work that has been compiled after wide practical experience, deep thought and much careful investigation. She is to be congratulated.

E. E. P. McM.

Sport

Rugby

GUY'S *v.* OXFORD UNIVERSITY.

(*Played at Oxford on October* 28*th*, 1944.)

Lost by 24 points to 11.

This was a magnificent game. Oxford, with one of the finest back divisions we have seen on the Iffley Road since the War started, started off the first half at a great speed. They were leading by 21 points to nil at half-time. A. H. Campbell, their captain, played a beautiful game at centre, either breaking through with his dangerous swerve or passing out to J. K. Pearce, his speedy wing and secretary. After half-time Guy's changed their tactics. Brittain and Mills kept a close eye on the mid-field players, and Batty-Shaw took over the leadership of the pack.

A. C. Bojé, from Pretoria, was playing in the centre. Unfortunately in this, his first match, his opposite number was A. H. Campbell, who proved too much for him.

In the first half the Dark Blues had it all their own way. Lennox-Cook, at stand-off half, had ample room to make openings for Campbell and Pearce. Campbell scored soon after the kick-off, and he and Pearce scored five times in the first half. Their back movements were a joy to watch. The Guy's backs were quite outplayed and the forwards did not help enough in defence.

After half-time Pearce scored once, but then the character of the game changed. The seasoned Guy's forwards kept the ball close and, with their stamina and experience, staved off disaster and almost won the match. Willcock supported them ably at the base of

the scrum and went over for a try. Bojé gathered a loose ball and staggered over for a try, converted by Dean. Brittain kicked a penalty goal. Until we get a reliable three-quarter line Guy's might employ these tactics more often.

The Boat Club

The Boat Club ended a fairly successful season—its ninty-ninth—by winning the VIIIs race of the United Hospitals Regatta on October 14th, 1944.

This year, as a result of evacuation and various other causes, Middlesex, London and Guy's were the only hospitals who entered crews, and the VIIIs race was the only event.

Guy's had the Surrey station; London were in the centre; and Middlesex off their own bank.

At the start all crews seemed to keep more or less together, until about the thirtieth stroke when Guy's suddenly realised they were a half-length up on the other crews and were still maintaining a high rate of striking.

Lowein gradually let the rate down to a steady row, but as he did so there was a momentary period of apparent inactivity on the part of the crew—a most alarming effect. However, Burns, in his old position of No. 7 and true henchman to stroke, clenched his teeth harder, dug his blade more firmly into the water—if that were possible—and, with the rest of the crew following suit, the first half-length was gradually increased.

London were slowly left behind with Guy's about one and a half lengths in front of Middlesex and, in spite of frantic efforts on the part of the Middlesex cox to assure his crew they were going up, they never quite made it.

Guy's won the race, with Middlesex a length and a half behind and London somewhere in the rear. The crew:—

Bow, J. G. Brett; D. Chapman; C. H. Williams; J. A. Bulleid; C. C. Bull; W. van 't Hoff; T. H. S. Burns; R. T. Lowein (captain and stroke)); A. Shotts (cox).

The other events of the season were equally as satisfactory. First there was the Head of the River race in March, in which Guy's ended fourth over a three-mile course, losing only to Imperial College and two semi-professional crews.

Then at the end of May a scratch crew was entered for Putney Regatta, but lost to Imperial College and London Hospital.

Later, in the middle of July, the VIII raced London over a mile course at Putney and won by about four lengths.

Two other races against Middlesex and University College Hospital were arranged, but were later cancelled at the last minute.

In August a United Hospitals crew went to Weybridge Regatta and was coxed by Shotts. Lowein, captain of the United Hospitals Boat Club, was, unfortunately, unable to row on that occasion.

The number of events has been necessarily small this year, but it is to be hoped that next year the club's centenary will be celebrated on a slightly larger scale.

C. C. BULL,
Hon. Sec.

Hospital Information, etc.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

October, 1944.

Surgery.—*M. J. Blunt, *E. D. C. Jones, *R. A. Leeming.

Pathology, Bacteriology and Forensic Medicine.—*E. D. C. Jones.

Medicine.—K. Lewis.

Midwifery.—*D. T. H. Paine.

* Have completed the examination.

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

October, 1944.

Pass.

L. W. Godfrey
H. F. Hills
I. Macdonald
H. W. Palmer, B.Sc.
R. C. W. Thompson
D. Q. Trounce
E. A. Wright

PART I.

E. R. Arnold
A. A. Cashmore
K. H. Chin
D. Davies
S. Davis
A. St. John Dixon
G. Forrester
G. E. Griffiths
T. G. Hooson
J. D. Huntley
M. B. King
W. R. Lee
J. W. Lewis
J. B. Musgrove
P. F. New
D. P. Nicholson
N. G. Nicholson
T. E. Norman
G. F. Penny
J. M. Pugh
C. G. Roberts
J. F. Shaw
R. G. Walton
P. Westcombe
F. R. M. Young

PART II.

J. N. Hunt
R. C. Jennings
E. G. Murphy

PART III.

K. R. Brookes
A. S. R. Cini
R. G. G. Jones
H. A. Lane
P. C. Leeson
D. O. Lloyd
N. K. Macrae-Gibson
D. P. Nicholson
D. T. H. Paine
B. H. Pickard
A. G. I. Stockley

Change of Address

W. G. Gill, Surg. Lieut.-Cmmr, R.N.V.R. c/o Lloyds Bank, Reigate, Surrey.

Oliver Iye, 9A, Church Row, Hampstead, N.W.3. (Tel.: Hampstead 1014.)

W. G. Tillman, Major, 114 (Br.) General Hospital, c/o A.P.O.

S. M. Vine (325076), Lieut., R.A.M.C., Imperial Bank of India, Bombay.

T. A. Werner, M.D., 18, Wimpole Street, W.1.

Miss E. Waterman, c/o Dr. Stewart, Chaguanas, Trinidad.

W. Mark Brown, 389, Papanui Road, Christchurch, New Zealand.

S. S. Suzman, Lieut.-Col. R.A.M.C., 84, Harley Street, W.1.

Marriages

WETHERALL—CALDWELL.—On October 16th, 1944, at St. Mary's Church, Poona, Robert Guy Wetherall, Capt. R.A., to Ruth Vivian Elizabeth Caldwell, daughter of Dr. J. R. Caldwell, of Stoneleigh, Milnthorpe, Westmorland.

Births

MULLINS.—On October 22nd, 1944, at Grahamstown, South Africa, to Doreen, wife of M. R. Mullins, Lt., S.A.M.C. (6th South African Armoured Division Reserve Ambulance)—a son, Anthony Michael.

SCARLETT.—On November 8th, 1944, at Guy's Hospital, to Clare, wife of James Scarlett, Lieut., R.A.M.C.—a daughter, Claire.

Deaths

HARRISON.—On November 9th, 1944, at Huddersfield, Yorks, Edward Montague Harrison, M.B., B.S., aged sixty-three (England International Rugby player.)

POWELL.—On November 9th, 1944, A. C. Powell, Lieut., R.N.V.R. (Dental Student, 1940), aircraft crashed into sea.

Sector 10—House Officers

NOVEMBER 1st, 1944, to JANUARY 31st, 1945

Remaining	*New Appointment*	*Transferred from*	*Transferred to*	*Retiring*
GUY'S Hilton, S. M. Brangwin, P. L. (B.2) Garland, G. W. (B.2) Saunders, D. R. S. (B.2) Thomas, J. M. (B.2)	Trounce, D. Q. Pentney, B. H. Chapman, D. J. (Student)		Irvine, R. E. to Farnborough Fabricius, J. M. to Wildernesse	
WILDERNESSE	Thompson, R. W. C.	Fabricius, J. M. (B.2) from Guy's	Dickie, A. B., to Pembury	Hart, J.
JOYCE GREEN Haas, G. J. Sharp, C. L. E. H. (B.2)		Lillywhite, W. H. (B.2) from Queen Mary's		Knight, F. R. S. Kent, J. V.
PRESTON HALL Couper, E. H. (B.2)	Gibbs, A. E.		Coates, K. B. J. to Pembury	Emrys-Roberts, H. M.
ORPINGTON Hodgson-Jones, I. S. Bryant, P. D. (B.2) Keates, M. D. (B.2) Williams, O. H. E. (B.2)	Wright, E. A.			Hollis, P. W. T.
FARNBOROUGH Finney, R. (B.2) Brightwell, P. (B.2)		Irvine, R. E., from Guy's Palmer, H. W., from Pembury	Dodd, F. G. B., to Southern Allen, R. A., to Lewisham	
PEMBURY Merrick, H. P. (B.2) Evans, M. E. (B.2)	Macdonald, I.	Coates, K. B. J. from Preston Hall Dickie, A.B., (B.2) from Wildernesse	Palmer, H. W., to Farnborough	Wright, E. G. Brown, D.E. M.
SOUTHERN Poots, A. V. (B.2) Lee, A. B. (B.2)	Godfrey, L. W. Jones, E. D. C. Ebsworth, J. S. Leeson, P. C. (Student)	Dodd, F. G. B. (B.2) from Farnborough		Fry, J. Gough, K. M. McKeown, T. Mars, P. E. Drewitt, A. H.
DARTFORDCOUNTY Lorber, J. (B.2)				
LEWISHAM		Allen, R. A. (B.2) from Farnborough		
QUEEN MARY'S		Johnson, W. C. (B.2) from St. Alfege's	Lillywhite, W. H. (B.2) to Joyce Green	
ST. ALFEGE'S			Johnson, W. C., to Queen Mary's	

EDS. {J.P.M.B. J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

OSLER, in his essay "Chauvinism in Medicine," writes: "Let our young men, particularly those who aspire to teaching positions, go abroad. They can find at home laboratories and hospitals as well equipped as any in the world, but they may find abroad more than they knew they sought—widened sympathies, heightened ideals and something perhaps of a *Weltcultur* which will remain through life as the best protection against the vice of nationalism."

These words were written in 1902. Since then much has been accomplished towards the destruction of this nationalist outlook in scientific medicine. Most of us are too young to remember the bitter controversies which raged between German and French bacteriologists towards the end of the last century. It was a very real force which we can with difficulty appreciate to-day.

Now the position is greatly altered and we take for granted such things as international congresses of this or that medical or surgical specialty and the invitation of visiting professors from foreign countries, a form of hospitality at which our American Allies excel. Medicine's greatest achievement, however, in this international sphere was the setting up of the International Health Bureau at Geneva as a part of the League organisations. Though the League failed, the Bureau has continued to flourish, even in wartime, and has performed a great deal of useful work in the sphere of public health and epidemiology, particularly in the Far East, where so much disease is endemic and control is difficult because of ignorance, low standards of living and apathy.

Scientific exchange, from being a valuable and useful procedure, has become a necessity. So large is the field of research to-day that a worker in one part of the world may find himself quite unwittingly performing experiments which have been tried on the other side of the globe, thus wasting a great deal of time, energy and money.

Scientific exchange, criticism of work and ideas are pre-eminently stimulating to both sides taking part. Clinicians, in particular, may benefit from travel since they may be enabled thereby to study a particular disease more profitably in other countries. We remember that the late Sir Arthur Hurst's work on peptic ulcer was much stimulated by contact with Continental clinics.

All the modern masters of medicine have held this internationalist outlook, and they would be the first to admit that no single nation holds a monopoly of scientific achievement.

In conclusion we have tried to "inveigh against this cursed spirit of intolerance, conceived in distrust and bred in ignorance . . ." and we have tried to make out a case for inter-nationalism, at least, in Medicine. "Let our young men . . . go abroad." Splendid! But how can we implement this ideal? Where are the facilities, who is polylingual, and whose pocket is deep enough? We can find no reference to these aims in the Goodenough Report. It is indeed quite a problem, but one which, we venture to suggest, is worth facing up to. Its solution may help us to spread, not only scientific ideas, but it may help to dispel the clouds of distrust which abound in the realms of international relationships.

A NEW star has appeared in the firmament of medical journalism. There has appeared in the Medical School a wall newspaper with the arresting title of *Pulse*. The first issue appeared a fortnight ago and it will appear at further fortnightly intervals. We suggest, in passing, that publication dates should alternate with those of the *Gazette*. The occasion prompts us to draw comparisons between the appearance of *Pulse* and the *début* of *The Guyoscope*, which first burst upon us in 1897, receiving the most flattering attention from the London Press. Alas, however, the life of *The Guyoscope* was meteoric in its rise and fall, and we trust that *Pulse* will not share a similar fate.

We have been told that the purpose of *Pulse* is not to rival the *Gazette*, but to supplement and enlarge upon the personalities and affairs of the Medical School and its students. We ask our readers to bear in mind the fact that the majority of our subscribers are members of the Hospital who have long since left when they criticise us for the absence of gossip in our columns, of interest only to the present generation.

Therefore, we feel that *Pulse* fills a much-needed gap. In wishing good luck to this venture, we trust that the beatings of *Pulse* will be regular and of good volume.

THOSE who suffer from Vitamin A deficiency will be glad to hear that it is no longer dangerous to walk in the Park after dark, for the Park and the Colonnade are now bathed in light :—

"Time was when men would grope their way across the Park
Barking their shins against consultants' cars.
Then was Peter, our Bishop of Southwark, overheard to remark,
'Let's have some light! Those cars must needs impress the upper class.'"

WE have been asked by the Medical School to bring the following Resolutions from the University of London Senate House to the notice of London M.B. candidates :—

1. That the reduction of the clinical course for the M.B., B.S. examination from three years to thirty months be continued during the session 1944–45, but that the question be further considered in the third term of that session.

2. That, as a war measure, candidates who satisfy the Examiners in one subject only of Part III of the M.B., B.S. Examination be credited with that subject and allowed to enter for re-examination in the other subject only.

This latter resolution will come into force at the next M.B., B.S. examination in February, 1945, and is limited to the war period.

WE would like to congratulate Sir Herbert Lightfoot Eason on his re-election as President of the General Council of Medical Education and Registration of the United Kingdom for the ensuing 3 years, and Dr. A. D. Marston on his election to the Presidency of the Association of Anæsthetists for the year 1944–45.

The Psychiatric Battle Casualty

A Lecture to the Battalion Officers by H. A. Ripman, M.B., B.S.

THE psychiatric battle casualty is the man who becomes an invalid in battle (less often before or after battle) as a direct result of the inability of his personality to stand up to the strain of his environment—that is, the strain of the circumstances imposed upon him in battle.

His existence requires recognition, because in various forms he represents from two to ten per cent. of the total number of casualties evacuated from the field of action, and many more—invalid to a lesser degree and not requiring evacuation—who become decreasingly efficient soldiers and a strain on the unit morale. An outbreak is liable to have infectious characteristics, and on this account requires the earliest possible recognition, because by this, not only can the man be helped and saved from a complete breakdown, but the unit can be saved from an epidemic.

Essentially the cause of this condition is fear and a brief consideration of this emotion will lead to a fuller understanding, not only of psychiatric casualties as a species, but of the man as an individual.

In animal life three instincts stand out above all others. They are the instincts of self-preservation (the strongest), the instinct of self-propagation (or reproduction) and the instinct of self-nourishment. These three are extremely necessary to man's equipment, because without them the continuation of life would be, to say the least, precarious. They are therefore extremely deep-rooted in each individual, and normally their fulfilment or sublimation takes precedence over all other forms of activity when the need arises. Combined into one entity they are what is now understood by the word, originally coined by Freud but since broadened in its meaning, "*libido*." Their existence is less and less conspicuous the further up the animal scale one climbs, and

in man they are seldom obvious. The instinct of self-nourishment is depressed by various modifying influences inherent in our civilisation. The instinct of self-propagation is tampered with, sometimes catered for and frequently denied, by the society which we have formed and in which we live. The instinct of self-preservation in the more ordinary times of peace is seldom called upon, but in times such as these presents for each one of us a very pressing problem.

To answer this instinct of self-preservation, when a threat to one's existence is impending or evident, there are two possible natural reactions—fight or flight. Some species of animals generally react actively; they are the lions of the universe. Others generally react passively, and they are the rabbits of the universe. But most are left indeterminately to choose, between fight and flight, anger or fear. Man "normally"—depending to a certain extent on "what breed of man he be"—reacts by taking the course which will give him the greatest personal chance of survival. The word "normally" is important because by an appreciation of this principle one is bound to acknowledge as normal the emotion of fear in battle, where man, the individual, is up against a collective strength greater than his own armament provides. Individually he has no chance, and the natural reaction therefore is flight; his normal emotion, fear. (See Table.)

TABLE.

Instinct.	*Chances.*	*Emotion.*	*Reaction.*
Self-preservation	Good.	Anger.	Fight.
	Bad.	Fear.	Flight.

If we admit, then, that fear is normal, we should expect to find that this natural reaction carries with it some assets. Physiologically it does. The body's internal reactions to anger and fear are identical. Amongst other things adrenalin is secreted into the blood-stream. The hairs stand on end to give an apparently increased stature in the eyes of the foe. The liver pours out sugar so that the muscles may have ready access to fuel either for the exertion of battle or the equal exertion of swift flight. The bladder empties and the man is ready for the occasion.

Without awareness of danger there is no fear. Conversely, fear is the emotional expression of the perception of danger. If an officer, discussing the plan before battle, says he is afraid for his right flank, that is a healthy fear. It is a sign of his awareness of the danger to his right flank and a symbol of his preparedness. The phlegmatic individual who is literally without fear is not wholly at an advantage over his more fearful brother. Admittedly fear before the event, or apprehension, is, perhaps, more valuable than fear at the time, but in small quantities they are both healthy fears. Fear stimulates attention, sharpens judgment and evokes a maximal effort. Only when fear dominates the mind to the exclusion of all other thoughts is it harmful and, when in excess, a deadly disease.

Fear does not always walk naked and unashamed. In some people she does, but in many she is clad beyond recognition because she is ashamed. This clothing, this barrier which prevents fear from appearing beyond the confines of the mind, is, to use the Freudian terminology again, the "*super ego.*" It is the product of upbringing, self pride, sense of duty, the competitive spirit, the determination to show one's worth and a thousand lesser influences. It is the hall-mark of the social animal.

In the mind of the man in danger there are, then, these two great forces—the "*libido*" and the "*super ego.*" If the "*libido,*" the natural desire for self-preservation, is high, and the "*super ego,*" the barrier, low, then fear will overflow and manifest itself. If the "*libido*" is high and the "*super ego*" high, too, then, though the barrier may hold, there will be a stress between these great mental forces and there will be "conflict." And not only will there be conflict, but if at that moment any more cause for fear, any more stimulus to the instinct of self-preservation be added, "*super ego*" may no longer be able to hold "*libido*" in check, an expressed fear will overflow, and, indeed, may pour over the barrier so fast that "*super ego*" becomes worn away. Then fear will be naked.

That is the picture of the turmoil in the mind of the psychiatric battle casualty in its simplest form. But it is obvious that all these forces are variables. The instinct

of self-preservation, the naturalness of fear, will vary in different individuals. As no two men regard an equal stimulus as causing the same amount of physical pain, so will no two men fear the same situation or environment equally. The man's individual valuation of life alone will modify the intensity of his desire to live. The "*super-ego*," the dam to the expression of his fears, will vary not only between men of different upbringings, education and values, but in the same man at different times. It will be lowered by fatigue, by pain, by hunger and thirst, and not least by non-battle stresses. These non-battle stresses are of great importance. Few factors can adversely influence a man's resistance to fear so certainly as worrying about affairs at home. In this way the man who has seen his wife recently, seen her well, and hears from her regularly is placed at a great advantage over his fellow-soldier who has been stuck away on the other side of the globe for three years and has to rely on irregular and long interspersed letters from home for reassuring news about his wife. And a man who does not get along well with the other men in his troop or is unpopular, is subjected to a similar non-battle strain.

If these forces, then, are variable, advantage must be taken of their variability. Clearly our duty must be to add every hindrance within our power to the sublimation of "*libido*" by flight, and to load the scales in favour of the "*super-ego*" as much as possible.

How can one reduce a man's tendency to answer the instinct of self-preservation by flight? The alternative answer is "fight," and, as was pointed out earlier, the individual tends to react in the manner which offers him the greatest chance of survival. If, then, by training and presentation of the circumstances, we can satisfy him that to fight gives him the greater chance, such will be the trend of his *libido*, and its sublimation will be to military advantage.

The naturalness of the response to battle environment by fear and flight depends on the deep conviction that the man's individual armament is inadequate to combat successfully the combined forces of the enemy which appear to be pitted against him, the individual. Firstly, we must endeavour then, to make him lose that "individual" feeling. He must be trained, when summing up the chances, to estimate the forces at the enemy's disposal against the forces, not at his individual disposal, but at the disposal of his unit. This is automatically achieved, to a certain extent, in an armoured unit by the disposition of the men, five men being part of one weapon, a tank, and their fates, on almost all occasions, being rigidly bound into one. But a better state of affairs still would be that the individual should realise himself to be an integral part of his battalion, his brigade, his division, his corps, and his army. The larger the body of which he feels himself, deep down, to be a member the larger will be his estimation of his own armament, and the more likelihood is there that he will achieve the conviction that his survival depends on performing his duty as a cog in that machine.

A spirit of *camaraderie* will lead to this feeling of identity with his unit. One sees its advantages in men who have long trained and fought together, and probably never have so many individuals identified themselves so intensely with so large a force as when the soldiers in North Africa identified themselves with the Eighth Army.

For some men this loss of individual identity and incorporation is difficult to achieve, and the man who feels really on his own will soon find himself unable to subdue his tendency to save his individual skin, and will become a psychiatric casualty. In these cases it has been found that the appointment of two "battle friends," to look after such a man, can do great good, and if the man cannot imagine himself incorporated in a battalion unity, at least he can become part of "Three Musketeers."; at least he can increase his armament three times.

Confidence in his weapons, likewise, will help a man to the conviction that to fight gives him a chance of survival. Nothing reduces the guts in a man more than the fear that he is under-armed. Quite naturally, if such is his impression, he at once responds to danger by taking the line which assures the greatest chance of survival—namely, fear and flight. But if he is convinced that his weapon can be relied upon, then he will respond to the situation by holding his ground.

We can therefore, if we train a man to lose his individual identity, to feel, in fact, gregarious, and have confidence in his weapons, not, perhaps, reduce his *libido*, his instinct of self-preservation, but turn it to military advantage by making its sublimation a matter of fighting and not fleeing. Then will "*libido*" and "*super-ego*" not be at variance, and in this ideal state of affairs there will be no conflict.

Whether, then, the "*super-ego*" is aiding and abetting the "*libido*" when the inclination is to fight, or restraining the "*libido*" when the inclination is to flight, the higher and the stronger the "*super-ego*," the better equipped will the man be. How, then, can this "*super-ego*" be varied to his advantage?

As mentioned already, fatigue, hunger, thirst, pain and non-battle stresses, all lower a man's resistance, and their reduction to a minimum will raise his "*super-ego*," his barrier. Battles must be fought and men are bound to become tired, but if every effort is made to see that they snatch some sleep when the situation permits, extreme fatigue or exhaustion can be avoided or postponed. Good food, hot food, whenever it is humanly possible, will keep them in good heart. If a man's wife is ill at home, or rumour has it that his home town has been subjected to an air-raid, then he is bound to be worried, but "better the devil you know than the devil you don't," and regular letters from home, brought up to the fighting soldier whenever possible, will be well worth the trouble it takes to accomplish. Finally, confidence in his immediate officer, his troop leader, and a feeling of mutual good will, interdependence and trust, and of a load shared evenly under even circumstances of existence, can elevate his sense of duty, determination to do good and acquit himself well, his self-respect and his pride in his job, beyond words, and that is his "*super-ego*."

Before proceeding to a description of the appearance of a psychiatric battle casualty and his treatment, it would be worth while briefly to summarise and define the conclusions to which we have come about the genesis of such a case.

The instinct of self-preservation can be sublimated by fight or flight, and to aid fighting or resist flight there is courage or a high level of "*super-ego*." Courage is not identical with fearlessness. Fearlessness is the absence of the emotion of fear. Courage admits fear, but denies the natural fulfilment of it by flight. An atmosphere of courage, then, rather than atmosphere of fearlessness is good morale. Good morale may produce fearlessness by encouraging the individual to identify himself with his unit, and giving him confidence in his weapons, but it will also help him to combat fear. The factors which go to make up good morale in this respect are the alleviation of non-battle stresses (regular mail and good welfare services), prevention of exhaustion, good food and faith in the leader. Add to these a sense of curiosity towards the new environment, attention to a job in hand which is part of an understood cause, and the knowledge that should he become a casualty there is first-aid and a satisfactory medical service at hand; add these and even the rabbits of the universe should be able then to resist the instinct to flee and endeavour to attain their objective.

Such, then, are the factors concerned, and I think it is clear that the balance can be heavily weighted against the incidence of psychiatric casualties. But even so, some will without doubt occur, and one must learn to recognise them quickly in order to treat them with the utmost speed, which in these cases leads to the utmost success.

Primarily, these will be two types—the pure "fear casualty" and the pure "conflict casualty." The former, the pure "fear casualty," is the man with a high level of instinct for self-preservation by flight and a low resistance to the sublimation of that instinct; the man in whom fear overflows the barrier and pours forth manifest.

His symptoms will be those of fear. He will display anxiety and may not sleep, will tremble and sweat; may be garrulous and talk rapidly, possibly somewhat incoherently, changing the subject frequently, thus showing his inability to dwell for long on one line of thought. He may frequently have to pass water and his bowels may be loose. His appetite is often poor. He may, being normally a moderate smoker, smoke in excess, or a moderate drinker, drink in excess.

It is clear that to enumerate fully all the signs that he might display would take a long time, but if one thinks back to the occasions on which one has known fear oneself, then it is fairly easy to picture the man. What must be realised is that the display of fear is disproportionate to the environment at the moment. Some quite petty danger may be the last drop, which, added to the brimming "*libido*," enables it to pour over the barrier, wear away that barrier, and allow the suppressed fears of the last few weeks or months to come pouring over after.

The onset may be slow and insidious and its recognition demands keen observation in the early stages. Or it may come on acutely and the man may be seen for the first time in a fully fledged state of panic.

Finally, and this is most important, a state of fear which may have been suppressed during the whole period in which it was engendered may display itself when all cause

for fear has gone, because when all cause for fear has gone all means to resist fear—that is, sense of duty, curiosity, anger and pride and interest in the job—may have gone, too. The man is left without arms to contemplate the nearness of his mortality. And this "fear neurosis" may linger on, for, in the same way as a man who has been depressed for a long time by a series of tragedies, may, when all tragedy is past, be found to be permanently depressed, so may a man, for a long time under the influence of fear, permanently display the symptoms of being afraid. A careful watch must, therefore, be kept at all times, even when the battle is over.

The pure conflict neurosis arises in the man who, although he has a high level of inclination to flight, has also a high level of other factors in his personality which resist the fulfilment of that inclination. He therefore shows no fear, but is subjected to the conflict between his emotions.

Most of us have at various times known this feeling of conflicting emotions ourselves, and by recognising what we felt at those times we can enumerate the symptoms of the conflict casualty. There is a sense of indecision, insecurity, uneasiness and tension. It is, in fact, a state of anxiety. Under these conditions a man who is usually quiet may become extremely talkative, because by talking he feels he can liberate some of those pent-up forces within him. Another man, usually talkative, may become quiet, because he is unable to maintain a sufficiently steady flow of thought to hold a conversation. Some men will become so tired from the mental conflict that they will be almost stuporose. Others will be so worried and disturbed by the tension that they will suffer from insomnia and lie restless all night without sleep. The usually placid man may become difficult and argumentative. The good honest soldier may become a petty criminal, and having had a previously blank crime sheet, may start coming frequently to "orders." In more advanced cases loss of memory, obsessions and completely ungrounded and futile phobias may occur. Those are the types of character change which, if noticed, will lead one to suspect a conflict neurosis. They are the products of that feeling of tension and uncertainty arising from conflicting emotions which we all have known.

Before leaving our consideration of the symptoms it must be thoroughly realised that these are only the "early stages" of the "pure forms" of psychiatric casualty. I accentuate "early stages" because if these symptoms are allowed to persist, a far more serious breakdown of the personality will occur. And I say "pure forms," because in a large percentage of psychiatric casualties, fear and conflict are found together.

Finally, we come to the matter of treatment. This is so akin in principle to the treatment of the physically wounded, that the parallel might be profitably considered.

Prevention is of great importance. In the same way as precautions are taken, by means of training, to inflict maximal casualties on the enemy with minimum hurt to our own troops, so by using our knowledge of the genesis of fear and the properties of morale, we can minimise the incidence of mental breakdown.

As the wounded man goes through several grades of treatment during his evacuation, so does the psychiatric casualty. He, too, requires first-aid at the earliest possible moment. This must be done on the spot at once and is seldom curative; usually a matter of preventing a further deterioration in the patient's condition. Some cases, with firm sympathetic reassurance, and an understanding but not too lenient, helping hand will be able to finish the battle. This should always be a matter of leading rather than pushing, and the officer who thinks he can cure anything by means of a hard kick in the pants forgets that by commission he is a leader, and must, indeed, be a contortionist to do both at the same time. For the really acute case, the man who goes "berserk" in the middle of battle, an injection of morphia is all you have and will do great good.

Most cases will require more than just this reassurance, however, and must be evacuated with all speed. The medical officer will administer large doses of sedative drugs, and attempt to prevent the condition from establishing itself, and throughout the process of evacuation the patient will be kept under sedation, because by this means the psychiatrist's task is greatly facilitated, and his return to the line of battle will be considerably hastened. And remember, when he does return, that is the time, above all, when he wants to be put among his friends, back in his own troop, or better, his own tank.

That I think, is as simple an explanation of, and as good advice for the psychiatric battle casualty, as I can give you. And if you will forgive this final reiteration, the greatest hope of avoidance of these cases lies in convincing the man that fight is safer than flight. Fight and survive. Fear and be slain.

Mr. Willink and the B.M.S.A.

By I. A. H. MUNRO.

THE Minister of Health paid a compliment to medical students by attending a session of the annual general meeting of the British Medical Students' Association on November 10th, 1944. David Pyke, the retiring President of the Association, presented the Minister with the results of the questionnaire on the White Paper conducted by the Association. Although answered by only 30 per cent. of medical students, the questionnaire still represented the broadest survey ever made of medical student opinion on any subject. The great majority of answers received were in favour of a comprehensive medical service free to all, and of the " health centre " as the unit of such a service. Students, however, were suspicious of control by an appointed body and were anxious to avoid the introduction of compulsory measures.

In his address, the Minister welcomed this expression of the opinions of medical students and said that, in order that he might continue to be so informed, he had agreed to a suggestion that the B.M.S.A. be represented in discussions between the profession and the Ministry of Health. In a brief survey of the White Paper proposals Mr. Willink said that one of the first aims was to overcome the financial barrier which stood between many of our people and the best medical attention. The service was, therefore, to be free to all. Further points which the Minister mentioned as awaiting remedy and for which the White Paper provided were the lack of integration of our health services and the inadequacy and uneven distribution of consultant service. He wished to see a co-ordination of the activities of voluntary and municipal hospitals, but he emphasised that there was no intention of bringing voluntary hospitals under the control of local authorities. The horrified cry of " Doctors will become civil servants ! " was frequently raised in opposition to the Government's proposals. Mr. Willink did not think that this ever came from the accredited representatives of the profession or from anyone who had carefully read the White Paper. " Whatever the detailed final arrangements may be," he declared, " I assure all of you who are going into the profession of this—that it will be based on the traditional personal and confidential relationship of people with doctors of their choice and not on impersonal relationship with any bureaucratic service." The Minister said that doctors would be allowed to practise outside the service and that those in the service would be no more restricted in their treatment of patients than elsewhere. He regarded the proposals as an extension of the National Health Service from the particular to the universal rather than something entirely new.

At a subsequent session of the meeting, Guy's secured its first representation on the executive of the Association when R. D. Walsh was elected to the responsible and exacting post of general secretary. We wish him every success in his new office.

British Dental Students' Association

TUESDAY night, November 21st, was a memorable one for all those who were fortunate enough to get a ticket to our first dinner-discussion, held at " The Miller," from 6 p.m. to 9 p.m.

Guy's were represented, as were King's College Hospital, the Royal Dental Hospital and University College Hospital.

Our guest speaker—Mr. A. R. F. Thompson, M.R.C.S., L.R.C.P., B.D.S.—presented us with a most comprehensive and enlightening discourse. " Towards Better Dentistry" was the subject and Mr. Thompson is to be admired and congratulated, for he not only touched matters concerning dental prosthetics, conservative dentistry and dental economics generally, but also described specific procedures (or " time and worry-saving dodges ") that he uses in his operative tasks.

When the meeting was thrown open for discussion, above the sound of much quaffing of ale, a lively interest could be discerned. Subjects discussed varied greatly, and the ease and freedom and the complete open and honest way in which words flowed is much to be admired. All students are to be congratulated on their fine co-operation in the success of this initial undertaking.

Special thanks and inspiration must be shown to all those students in their first and second years who came along to this meeting, especially to those who contributed to the discussion. We are keen that you make yourselves heard at all our future meetings, and that a departure be made from the time-honoured tradition of "Silence from the Labs."

Mr. J. Mansie is to be thanked for spending an evening away from home with us at "The Miller," and giving a valuable contribution to the discussion.

We are proposing to hold a meeting in January, 1945, when the interim report of the Inter-Departmental Committee on Dentistry will be discussed. This report is of such vital importance to every dental student that the Southern Regional Council expect an attendance of 250 students.

This report is as important to pre-medical dental students as finalists. A copy of this report should be possessed by each dental student and studied with due interest. A copy should be obtained from H.M. Stationery Office, your local newsagent or your B.D.S.A. representative, price 6*d*. Date and guest speaker to be announced.

P. SHINGLER,
DAVID BAKER,
Guy's Representatives, B.D.S.A.

Orpington Letter

IT is many months now since a letter from Orpington has appeared in the columns of the *Gazette*—too many months indeed, for we are now beginning to hear views of ourselves which we are anxious to correct, among which is the idea that we are solely an orthopædic centre. It is true that we have a very large number of orthopædic beds, both military and civilian, but we can also boast a number of beds allocated to general surgical, medical, gynæcological, genito-urinary, and E. N. T. cases, sometimes in excess of the number usually allocated to these departments at Guy's in peacetime. We can therefore say that we can give as varied experience to our staff, both medical and nursing, as is obtained in many, if not most, of the other hospitals of the Sector. It is true that we do not "take in" from the surrounding district, but in some degree this is compensated for by the "take in" from surrounding Military and Air Force camps and stations. Imagine, then, our hurt feelings when we hear: "Oh! Orpington—you will never learn anything there but orthopædics!" In point of fact, a recent comparison showed that in one week we exceeded, in major general and special operations, the number of similar procedures at Guy's for the same period, without our counting a single orthopædic operation.

We do not state these facts in any proud complacency, but merely to dispel a rumour painful to ourselves and, having done so (we hope), we will not further mention it.

We have lost this week one of our oldest friends, B. J. Fowler, who has been with us for almost three years, and has left for the Army. During his period of residence he has earned the highest esteem from all, both for his surgical ability and outstanding personal integrity. We wish him well.

B. D. J.

Correspondence

"SPRINGFIELD" BABIES' ORPHANAGE, FATSHAN, SOUTH CHINA

To the Editor of the GAZETTE.

THIS orphanage is attached to the Fatshan Mission Hospital. The Matron, Miss Kathleen Banks (Guy's 1918–22) has been interned by the Japanese at Canton for the last two and a half years. The children are now in Free China in charge of a Chinese Sister (Agnes Chan), who was Assistant Matron with Miss Banks, and who was trained at Toronto General Hospital.

Funds are sent out each month and the orphanage is entirely dependent upon what is sent. Guy's nurses and their friends have already sent £229 2*s*. 3*d*.

Excerpt from letter received from the Methodist Missionary Society (2/10/1944).

"You will be glad to know that owing to the generosity of friends in England and China, we are no longer worried about the support of the orphans. . . . We like to think

that from this Orphanage one day will come perhaps ministers, nurses, teachers and others to serve in the Church. . . . We think that the Guy's nurses would probably like to know that it is their generous gifts which are partly responsible for the better financial position of these orphan children, and we are very grateful to them."

Contributions are sent to the Secretary each month by Sister Hilda Gration at Orpington, to whom donations should be sent.

SUBSCRIPTIONS, ETC., OCTOBER, 1943—1944.

Dance (S.C.N. and S.N.A.), Pembury	£35	0	0
Whist Drives (Orpington)	4	0	0
Sale of Work (Orpington)	15	0	0
Dance (Orpington)	6	2	0
Dance (Orpington)	19	7	0
Dance (Orpington)	22	16	0
Dance (Orpington)	7	10	0
Dance (S.C.N.), Guy's	7	0	0
Dance (S.C.N.), Guy's	2	10	0
Wildernesse	3	16	3
Harvest Festival, Orpington	2	0	0
Subscriptions and Donation from Guy's Nurses (Past and Present) and their friends	104	1	0
	£229	2	3

CHILDREN'S CHRISTMAS TEA.

To the Editor of the GAZETTE.

SIR,—It is proposed once again to give a tea to the children of the Borough in the Out-patient Hall on Christmas Day.

It is thought that your readers might like to the reminded of the origin of this tea. This function first took place on Christmas Day, 1897, and was organised by Mr. T. W. H. Landon. A fund was started and ever since then this Landon Tea has been one of the chief events of the Christmas holiday. Donations to this fund have been made by good friends inside the Hospital and also by firms and factories in the neighbourhood.

Thanks to the generosity of these donors it has always been possible to give the children of the Borough who have been Hospital patients during the past year a jolly Christmas afternoon and a present each.

During the War letters have not been sent to the Staff asking for their support because the number of children available has been considerably smaller than in peace-time.

Next year it is hoped that the tea will once again reach pre-war proportions and we shall then be grateful for all the support that kind well-wishers may be disposed to give.

In the meantime it is hoped that this year all whose duties will keep them at Guy's on Christmas Day will lend us their goodwill and practical assistance to help us to make this occasion as much of a success as the previous Teas have been. Anyone willing to help should get in touch with Sister Out-patients, who is the honorary secretary and the organiser of the Tea.

Yours, etc.,
P. M. F. BISHOP,
Acting Chairman, Landon Tea Fund Committee.

Guy's Hospital, S.E.1.

LADY BONSOR'S MEMORIAL.

To the Editor of the GAZETTE.

SIR,—At the time of the death of Mabel, Lady Bonsor, the Guys' Hospital Ladies' Association opened a fund for the endowment of a cot in Guy's Hospital as a tribute to her memory.

The sum of £393 towards the required £500 has now been received. It is proposed to close this fund at the end of the year, but any further contributions will be most gratefully received in the meantime by the Hon. Treasurer, 92, Exeter House, Putney Heath, S.W.15.

Yours, etc.,
D. M. SANDERS, Hon. Treasurer.

AN APPEAL.

To the Editor of the GAZETTE.

SIR,—The squash courts were installed at considerable expense and the cost of running them is borne by the Clubs' Union. The amount spent annually is well over £100 and the charge of 1*s.* per hour barely covers the lighting. Unfortunately, the electric light meters are frequently tampered with and damaged, so that the Clubs' Union thereby sustains a loss.

The Clubs' Union Council feel that the above facts should be made known to members in the hope that the trouble will not recur.

Yours, etc.,

F. R. KILPATRICK.
Hon. Secretary, Clubs' Union.

Guy's Hospital, S.E.1.

"COMBINED ROUNDS."

To the Editor of the GAZETTE.

SIR,—We wish to record a plea for the revival of the "combined rounds" with which the name of the late Sir Arthur Hurst is indissolubly connected and which made so valuable a contribution to clinical teaching.

We hope that the rounds would continue to be supported by the varied retinue that came to Sir Arthur's court in former days. We feel that they would provide at once a considerable addition to our clinical training and a practical memorial to a great man.

Yours, etc.,

S. BALFOUR-LYNN, J. LUDER,
A. J. BEALE, I. A. H. MUNRO,
D. J. DENNISON, G. I. TEWFIK.
F. L. JACKSON,

Guy's Hospital, S.E.1.

Reviews

Brompton Hospital Reports. Vol. 12. 1943. Gale and Polden. *Price* 8*s.* 7*d.*

THE Brompton Hospital Reports is a publication of papers written by members of the Hospital Staff during the past year.

In this volume the more important contributions come from the pens of the surgeons. Price-Thomas and Cleland present a detailed article on extra-fascial apicolysis with thoracoplasty. The technique and complications are described and, in their second article, they discuss and analyse their results in the different types of operation.

Brock presents a strong case for early and radical surgery in the treatment of tuberculous empyema in his article on that subject, and his article on pleurodesis demonstrates the simplicity and efficacy of silver nitrate and its advantages over poudrage.

Tudor Edwards writes on traumatic hæmothorax. His advocation of air-replacement, even in the early stages, will not meet with universal agreement.

The chief articles from the physicians are by Brooks and Foster-Carter. The former writes on miniature mass radiography in the diagnosis of chest disease, and reaches the interesting conclusion that its primary indication is likely to be that of detecting carriers in the older age-groups rather than the detection of early cases in the young, if elimination of the disease on a long-term policy is aimed at. Foster-Carter contributes his excellent paper on the bronchial tree. It is most beautifully illustrated and includes some interesting experimental work.

The great majority of the above work is likely to be of value only to those specially interested in diseases of the chest. The book is not one to be recommended for undergraduate study. It is an attractively presented volume, price 8*s.* 7*d.*, and obtainable from the Hospital secretary. N. S.

Sport

Association

GUY'S *v.* UNIVERSITY COLLEGE HOSPITAL.

Won 2–1.

(*Played at H.O.P. on October 14th, 1944.*)

Starting immediately after a heavy shower, play in the early part of the game was scrappy, ball control being very difficult. If anything Guy's were having the better of the play, but the forwards were up against a sound defence, heavy and fast.

Guy's opened the scoring in the second half; Trist lobbed the ball over from the left for Sykes to head into the net.

Guy's, encouraged, pressed hard and after several attempts by most of the forwards to score, Munro, after being brought down in a heavy tackle, put in a quick fine-angled shot.

University College Hospital tried hard to find two goals in the short time they had left, but only one was forthcoming.

Team.—I. L. Busbridge, A. W. R. Williamson, C. S. Mathews (captain), E. M. Newton, E. G. Murphy, H. R. Riches, I. A. H. Munro, M. J. L. Sykes, A. E. Trist, W. A. Evans, M. Woolf.

GUY'S *v.* ST. MARY'S COLLEGE.

(*Played at Strawberry Hill, Middlesex, on November 11th, 1944.*)

Lost 2–4.

This game was played on a wet surface but, in spite of the difficulty of ball control, a fast pace developed. St. Mary's College showed considerable skill in dealing with the situation, their short accurate passing being more effective than the more open play that Guy's adopted. However, Guy's opened the scoring through Trist. Shortly afterwards St. Mary's equalised and began to show that they were the better side. They took the lead, *scoring a second goal before Trist again scored,* making it 2–2 at half-time.

In the second half the contest developed into a duel between the St. Mary's College forwards and the Guy's defence, in particular Busbridge. Playing the game of his life, he saved, including a penalty kick, all but two of the countless number of shots that were showered upon him from all quarters. Had it not been for this fanatical display the score would most certainly have been more than 4–2 against us.

Team.—I. L. Busbridge, A. W. R. Williamson, H. R. Riches, E. M. Newton, C. S. Mathews, F. R. M. Young (captain), R. A. C. Dove, M. J. L. Sykes, A. E. Trist, G. Roberts, R. Owen.

GUY'S *v.* IMPERIAL COLLEGE.

(*Played at Sudbury Hill on November 18th.*)

Drew 2–2.

Due to illness and the call of London University, Guy's were not able to field a strong side against Imperial College. Playing a spirited game, Guy's were unlucky not to win; in fact, the ball was on its way into the net when the final whistle blew and the goal was not allowed.

Imperial scored first and no further goals came during the first half, though the opportunities presented themselves at odd times to both forward lines.

Early in the second half Trist equalised for Guy's and a short time afterwards Riches put Guy's in the lead. In spite of Guy's efforts to maintain their lead, a few minutes from the final whistle Imperial College were awarded a penalty, when the Guy's defenders eventually had to resort to handling to prevent the ball from crossing the line. Its eventual transit over the line was inevitable, the penalty kick giving Garland no chance.

Team.—W. H. Garland, C. S. Mathews, C. B. Vaughan, F. R. M. Young (captain), H. R. Riches, G. Roberts, R. A. C. Dove, M. J. L. Sykes, A. E. Trist, D. J. Foster, G. Holding.

GUY'S *v.* ST. BART.'S.

(*Played at H.O.P. on Saturday, November 25th.*)

Lost 3–4.

For the first time this season Guy's were able to field a strong side against Bart.'s, who are at the top of the League.

In the first half Guy's kept the ball in the Bart.'s half most of the time and were making use of a strong forward line, keeping the Bart.'s defence very busy.

Guy's scored first from a short centre from the left which Sykes headed goalwards through a pack of defenders; a Bart.'s back attempted to clear, but the ball had already crossed the line.

Guy's scored again a short while afterwards, again from a centre from the left wing, Sykes volleying the ball hard into the net.

Bart.'s replied with a goal just before half-time, a header that went in off the upright.

In the second half Guy's seemed to slow up, and Bart.'s took the opportunity to equalise. Guy's rallied and took the lead once more through Munro, who, standing well placed, took a centre from Owen and put it in the net.

Bart.'s again equalised through a ground shot from a *melée* in front of goal that left Busbridge unsighted.

Finally, Bart.'s took the lead shortly before time from a break-through down the centre.

Team.—I. L. Busbridge, C. S. Mathews, C. B. Vaughan, E. M. Newton, H. R. Riches, F. R. M. Young (captain), I. A. H. Munro, M. J. L. Sykes, A. E. Trist, E. G. Murphy, R. Owen.

Hockey

October 7th, *v.* Weymann's at H.O.P. Guy's won 4–2.

Oct. 14th, *v.* King's College Hospital at Dog Kennel Hill. Guy's won 6–0.

October 21st, *v.* Richmond and Kingston Hill at Old Deer Park. Guy's lost 5–0.

October 28th, *v.* St. Bart.'s at H.O.P. Guy's won 3–1.

November 4th. *v.* Westminster Hospital. Guy's won 4–1.

November 11th, *v.* Woolwich Polytechnic at H.O.P., Lost 4–0.

November 18th, *v.* Middlesex Hospital. Guy's won 3–1.

November 25th, *v,* Charing Cross and Royal Dental Hospital. Guy's won 5–0.

Dec. 2nd, *v.* Broxbourne at Broxbourne. Guy's lost 3–4.

The 1st XI has been drawn from the following in most of its matches:—M. C. Gilbert, B. H. Prideaux (hon. secretary), D. C. Dawson, H. W. Trusted, L. D. Carton-Kelly, J. G. Richards, K. W. Bolt, C. M. M. Jenkins, T. C. L. Parry, J. P. M. Bensted, J. R. Burt (captain), D. R. S. Saunders, G. R. Wotton, J. D. Rumble.

Hospital Information, etc.

Notices

GUY'S HOSPITAL MEDICAL SCHOOL.
DEMONSTRATOR OF ANATOMY.

Applications are invited for the appointment of Demonstrator of Anatomy to commence duties on January 1st, 1945. Application forms may be obtained from the Medical School Office and should be forwarded to the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, not later than Saturday, December 16th, 1944.

Pass List

CONJOINT BOARD.
FINAL EXAMINATION.
October, 1944.

Surgery.

C. F. Allfrey	D. Q. Trounce
D. O. Lloyd	*A. B. Vanscolina
D. P. Nicholson	G. R. Wotton
*B. H. Pentney	

Medicine.

*E. W. R. Alderman	H. A. Lane
*F. J. Aumonier	R. P. C. MacDonald
*M. A. Barker	*B. G. P. Oakenfull
*C. B. Clarke	*P. F. Pearson
S. Davis	*B. H. Pentney
*J. S. Ebsworth	*J. S. Smith
N. R. Fenton	C. C. Vidot
*A. E. Gibbs	

Pathology.

C. F. Allfrey	B. D. Grant
E. R. Arnold	J. D. Huntley
J. P. M. Bensted	F. F. Jerichower
L. W. Bowen	T. C. L. Parry
J. Fifield	D. J. Rudman
G. Forrester	J. M. Thomas
J. Z. Garson	J. Walsh

Midwifery.

C. F. Allfrey	D. O. Lloyd
*C. B. Clarke	A. V. Morse
E. L. Dutta	D. P. Nicholson
J. Z. Garson	D. J. Rudman
R. A. Green	D. Q. Trounce

* Have completed the examination.

Guy's Hospital Medical and Dental Schools

CONFINED SCHOLARSHIPS IN SCIENCE.
July, 1944.

The following awards have been made :—

Medical School.

A. H. Phillips .. .. Scholarship.

Dental School.

Scholarship divided between—
H. E. Dyer and T. C. J. Price.

T. J. EVANS,
Dean.

Papers by Guy's Men

Croot, H. J. Operation for Hydrocele. Lancet, 1944, ii, 625.

Hartfall, S. J., and Another. Infective hepatitis in Malta Garrison. *Brit. Med. J.*, 1944, ii, 587.

Brock, R. C. The surgical treatment of carcinoma of the Œsophagus. *Post. Grad. Med. J.*, 1944, **20**, 287.

Bloom, H. Dysentery in British Prisoners of War. *Lancet*, 1944, ii, 558.

Campbell, Maurice. Systolic Murmurs. *Clin. J.*, 1944, **73**, 211.

Luntz, G. R. W. N. Diabetes Mellitus. *Med. Pr.*, 1944, **212**, 335.

Rushton, Martin A. The probable Age-Change in Incisor Dentine. *Brit. Den. J.*, 1944, **77**, 277.

Change of Address

J. A. Brocklebank, Major, R.A.M.C., 30 (Br.) General Hospital, B.L.A.

P. S. Clarke, Surg. Lieut.-Cmdr., R.N.V.R., c/o Grindlay & Co., Parliament St., S.W.1.

J. Cranfield, Captain, A.D. Corps, 543 Mobile Dental Unit, B.L.A.

D. Hand-Bowman, Captain, A.D. Corps, 1 Sub Unit, 39 R.H.U., 102 Reinforcement Group, B.L.A.

John Gordon (104978), Ft.-Lieut., B.M. (S.J.G.), London, W.C.1.

R. J. C. Grewcock, Captain, A.D. Corps, att. 64 General Hospital, C.M.F.

E. C. Hammond, Ft.-Lieut., R.A.F., Reykjavik, "A" British Troops, Iceland.

P. A. Lane-Roberts, Lieut.-Col., I.M.S., c/o Cox & King, Bombay.

T. L. T. Lewis (544889), Lieut. S.A.M.C., att. R.A.M.C., 12 British Field Ambulance, C.M.F.

H. C. Muirhead, Major, R.A.M.C., 101 (Br.) General Hospital, B.L.A.

K. W. N. Palmer (50353), Major, R.A.M.C., c/o Grindlay & Co., Bombay.

L. Pitt-Payne (234449), Captain, R.A.M.C., 128 (Wx) Field Ambulance, B.L.A.

Miss B. E. Thomas (5990), P.M., R.A.F.N.S., 24 M.F.H., R.A.F., Ceylon.

E. A. Williams (322504), Lieut., R.A.M.C., 2nd Medium Regt., R.A., C.M.F.

The Services

Killed.

Lieut. A. C. Powell, R.N.V.R.

Wounded.

Captain P. N. Swift, I.M.S.

Mentioned in Dispatches.

Surg. Lieut.-Cmdr. D. W. Burnford, R.N.V.R.

Surg. Lieut.-Cmdr. G. D. Channell, R.N.V.R.

Births

MORTON.—On November 15th, 1944, at the Private Clinic, 35, Drumsheugh Gardens, Edinburgh, to Kathleen (née Russell), wife of Dr. D. J. Morton—a daughter (Fiona Kathleen).

PAYNE.—On November 20th, 1944, at 17, Osborne Road, Windsor, to Zoe, wife of R. Vaughan Payne, M.Ch., F.R.C.S.—a son.

RAWLINGS.—On November 22nd, 1944, at Guy's Hospital, to Florence (née Poignand), wife of John Rawlings—a son (Arthur).

Deaths

COOK.—On November 30th, 1944, John Cook, M.C., M.R.C.S., L.R.C.P., of 14, Pemberton Avenue, Burry Port, Carmarthenshire.

RYGATE.—Suddenly on December 4th, 1944, at Gorseland, Bucklesham Road. Ipswich, Henry Bertram Rygate, M.B., F.R.C.S. (Edin.), in his eighty-first year.

EDS. {J.P.M.B. J.D.L.R.

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PASSIM

"WELL, Sam," said Mr. Pickwick, as that favoured servitor entered his bed-chamber, with his warm water, on the morning of Christmas Day, "still frosty ?"

"Water in the washstand basin's a mask o' ice, sir," responded Sam.

"Severe weather, Sam," observed Mr. Pickwick.

"Fine time for them as is well wropped up, as the Polar bear said to himself, wen he was practising his skating," replied Mr. Weller.

"I shall be down in a quarter of an hour, Sam," said Mr. Pickwick, untying his nightcap.

"Wery good, sir," replied Sam. "There's a couple o' sawbones downstairs.

"A couple of what ! " exclaimed Mr. Pickwick, sitting up in bed.

"A couple o' sawbones," said Sam. . . . .

"In other words they're medical students, I suppose ? " said Mr. Pickwick.

* * * * * *

It seems a fair supposition to make that the number of persons, alive or dead, who have undergone such an odd Christmas awakening could be numbered on the fingers of one hand, particularly when we read further and find that not only were the "sawbones" smoking cigars, but one was "a-drinkin' brandy neat, vile the t'other one—him in the barnacles—has got a barrel o' oysters atween his knees, which he's a-openin' like steam."

A rare and memorable experience indeed, such as could only befall those illustrious Pickwickians, gentlemen-adventurers, in an age of impeccable middle-class respectability, with Samuel Pickwick, that genial, spherical old fellow, who seems to embody in himself all the old Christmas tradition and custom.

When we come to consider the—shall we say ?—psychology of Christmas may we not pause and wonder why it is that even the cheapest and gaudiest Christmas-card which the Borough child sends to her father in Italy or France seems to have Mr. Pickwick

lurking in it somewhere ? Why are Christmases a hundred years ago looked back to with a sort of wistfulness by so many people, cynics apart ?

Can the answer be that the Pickwickians were the last of a generation who were able to enjoy their Christmases before the Juggernaut of the Steam Age fell upon the human race ? They only just managed to escape the hardening and de-humanising of their minds and spirits which the new era brought with it. Dingley Dell was never covered with a black pall of factory smoke, and the Fat Boy was never awakened by a mill siren. There was no eating of tinned turkey to broadcast carols, though, to be sure, many families in the country would probably have sat at a lightly furnished Christmas table at that time.

That is why we cannot help feeling that the idea of a " Christmas-card " Christmas represents a subconscious wish on the part of a great many people to recapture the spirit of those times without seeking in any way the return of material conditions which were, in so many aspects, evil and wicked.

" ' Time is always a-changin',' as the pickpocket said to the gen'l'm'n wen he was a-knockin' off his watch," Sam Weller might have observed in one of his more reflective moments. Indeed, one sometimes wonders why the human race continues to sentimentalise over Christmas in such a child-like way. For the perfectly obvious reason that humankind is just like an enormous child who takes a great delight in such pleasures. Whoever heard of a normal child hating Christmas ? It doesn't make sense. No ; Christmas is indeed a good thing. " And who in the name of heaven denied it ? " comes back the discomfited retort, showing how really child-like is this race of men, jealous lest it should be denied its chiefmost pleasures.

Christmas has always been essentially a family festival ever since it began two thousand years ago. It is the time for reunion between the head of the family and his poor relation who " casually looketh in about dinner-time—when the table is full." (Indeed, Lamb seems to have been plagued with them or had he to practise their arts himself ?)

A war-time Christmas can be a sad affair. Family gatherings are smaller and in the circle there are the empty chairs so full of meaning. Christmases in hospital, on the other hand, are traditionally gay affairs with the attempt made to recapture the family atmosphere. Here at Guy's celebrations will be austere compared with the jollifications of peace-time. To many of us the " Niggers " and the Children's Party are but legendary affairs. (Incidentally, we have been chuckling over some old photographs of the Niggers, and we think we can recognise not a few of the present members of the Staff arrayed in all their gaudies !)

We have drivelled far too long, so that as we close and raise our glasses to the toast of absent friends we wish that all Guy's men and women, past and present, particularly those abroad on the battle fronts, on the high seas or in prison camps, may be able to enjoy a Very Happy Christmas and may they be enabled to spend their next one here at Guy's or with their families at home !

Q.A.I.M.N.S.—Grey and Scarlet

IN scarlet and in grey she stepped,
And when she slipped away,
Grey, edged with scarlet, hung the pall
Spread by the dying day ;
And scarlet was the wound that shut
Those steady eyes of grey.

A. E. P.

Medicine and Morbid Anatomy

By HUGH BARBER,

Consulting Physician, Derbyshire Royal Infirmary; Medical Registrar, Guy's Hospital, 1903–1905.

FROM the time when Richard Bright could say: "What is found after death has been correlated with the symptoms during life," till the early part of the twentieth century, there were some eighty years during which almost all the great physicians had been morbid anatomists. The work in the medical wards was put on a sound basis and polypharmacy, which my teachers would call the "blunderbuss prescription," had become discredited in the light of what turned up in post-mortem to explain the patient's illness. Some of the die-hard prescribers might call Osler a therapeutic nihilist; but his results justified his use of six or eight drugs and "time in divided doses."

My clinical years at Guy's, from 1899 to 1905, were full of the spirit that the physician graduated to his status through morbid anatomy. All autopsies were made by the assistant physicians, and as medical registrar it was one's duty to deputise for holidays and at odd times. Clinical teaching in the wards was based on the subject. Sometimes rather too near the patient's bed, one of our teachers would ask what would be the appearance, "if you had this poor fellow's liver on a plate before you." He is reputed to have said: "Four patients in the ward, all dying from jaundice of a different cause—isn't it interesting?" This may turn our minds towards the problem of late manifestations of disease being too much in evidence in hospital; but the teaching was there all right and the student got his feet planted firmly on the ground. It was the custom for the physician, with his whole firm, to attend an autopsy on all important cases. It was rather fun for the assistant physician to produce the unexpected. Post-mortem porters were not such skilled technicians as they have become now; but they were great characters, who gave a hint when something unusual was in the wind. The type of man is illustrated by the story, in Campbell-Thompson's "History of the Middlesex Hospital," of the porter, who was asked about a post-mortem finding, and replied: "Well, sir, Dr. Volker 'e say it was a case of myercarditis; but what I say is, fatty 'eart's good enough for the 'ospital." It was the duty of our porter to keep the essential specimens for one of the physicians, who gave his own private morbid anatomy demonstrations to his firm. I can remember the added responsibility of dealing with his autopsies, lest one should miss a point about which he would make enquiries later. He had been, perhaps, the best morbid anatomist in his assistant physician time. If he did have a kindly criticism to make, it would only be: "You can't learn pathology in a day."

Perhaps in the nineteenth century Thomas Hodgkin was more of a pathologist and less of a physician than most of his contemporaries. The morbid anatomy records at Guy's Hospital began with the "Red Inspection Book" in 1814. Hodgkin, some ten or fifteen years later, started his good work as Curator of the museum, mounting specimens and getting out the catalogue; but, in the year of Queen Victoria's accession to the throne, he was passed over for the post of physician to the Hospital. It may have been that he was more gifted with the dead than the living. There is the story that he was called in to a very wealthy patient, with whom he stayed the whole night through. In gratitude the patient wrote an open cheque; and was very disgusted with Hodgkin when he filled it in for so small a sum as ten pounds. Hodgkin put his foot right in it, when he responded that he thought that was about as much as the patient looked as if he could afford, with the result that he was not called into that house again. Not evidence of a very good bedside manner; but, no doubt, his upbringing as a Quaker brought to mind the analogy of a camel and a rich man. When he failed to get the physician's post at Guy's, he became more interested in his gratuitous private patients than in those who paid fees. Anyway, when Hodgkin went on to the better world of his belief, he left his name in this one.

Laennec had taught pathology for five years and, about 1819, wrote: "Morbid anatomy is the surest guide to the physician." Wilks, in the eighteen sixties, uses almost the same words: "Pathology is the basis of all true instruction in practical

medicine." In 1907 Osler wrote of the changing times : " Saddest of all the chair of Pathology is no longer a stepping-stone to the chair of Medicine." It would be about this time that a whole-time pathologist took over much of the work from his assistant physicians. Times were changing, however, and pathology was not only digging deeper, but covering a wider field.

If morbid anatomy was put on a sound footing in 1761, when Morgagni published his letters on " The Seats and Causes of Disease " ; if it was established further by Matthew Baillie (the last to own the Gold-headed Cane) in 1788, then it was becoming highly specialised, about a century later, when he described the auriculo-ventricular bundle, and equally so in the first decade of the twentieth century, with Aschoff's work on rheumatic myocarditis and Sir Arthur Keith's recognition of the sino-auricular node. It was more or less inevitable that the whole-time pathologist should take over. In 1919 Osler appears to be resigned to this, because he suggests that the medical school rotates about the professor of pathology.

Medical science has gained ; the physicians can still attend autopsies ; but they lose something in not having the work of actually handling the specimens ; and scientific medicine also loses something.

Real co-operation is obtainable and brings the best results. If Addison could have worked with a clinical pathologist he would have gone further with the anæmia he described, but, in the disease which bears his name, it may have been an added stimulus to have the eleven pairs of suprarenal glands all to himself.

If one is writing in a reminiscent mood one need not apologise for a personal note. My introduction to the association of genu valgum with small fibrotic kidneys came from an autopsy I was asked to perform, on a boy who died in 1912, a few days after osteotomy. To have had this to oneself the world may have missed something scientifically, but it was a personal stimulus to look for other cases. When other children with the same clinical picture were discovered, it was my responsibility to keep in touch with them until the morbid anatomy could be investigated—sometimes ten or more years later. It is easy to use the expression " follow up," but a little selfish interest is helpful to complete the life-history of this type of patient, for whom there is little or no treatment of any value. They must be hunted up at regular intervals.

I would claim a wider point of view, however, about the clinician and morbid anatomy. It may be of value to question the relatives and the family doctor *after* a post-mortem examination. I remember a case of acute leukæmia with, on the face of it, a history of only a few days' illness, but, while slides were being prepared by a clinical pathologist for publication, I thought it worth while to visit the widow, from whom I learned that a year before the fatal illness the man had attended hospital for a swollen elbow ; at which time she had noticed little blue spots scattered over the back and chest. The elbow had been X-rayed, with negative result. An examination of the blood would have revealed leukæmia at this time, although one can scarcely call it latent if purpuric spots were present. They were hidden by his clothes. The dictionary meaning of " latent " is : not visible or apparent. A swollen joint may be one of the features of leukæmia. Latent is, to some extent, a relative term, dependent upon the observer. In this case, however, there had been no constitutional symptoms, and he had worked on a farm until less than a week before the fatal termination.

If one is not teaching students, a time may come when an autopsy on bacterial endocarditis, pneumococcal pneumonia or a cerebral hæmorrhage does not seem particularly important ; but an unexpected death in the street or on the operating table might give one a new line of thought. So with the accident autopsies, there may be something of a side-line not causing death—what might be called the by-products of the coroner's mortuary. These are the post-mortems which the clinician rarely sees ; and yet there may be a dumb mouth speaking, which he alone has ears to hear.

There is evidence to illustrate this line of thought in the matter of traumatic lesions of the heart. If we look in medical text-books published about forty years ago, we find the record of pathologists who have applied direct violence to the heart in the post-mortem room to find out if a valve could be ruptured by that means. It would appear that many of them succeeded ; although the dead heart seems a very different structure from one contracting, with a valve becoming tense. Of greater interest are the post-mortem records of traumatic valve lesions published by clinicians. For example (and

note the date), Wilks, in 1867, recorded a ruptured aortic valve from a fall. The specimen came from a young man who fell from a height; he was in a surgical ward for two days; he died of rupture of some abdominal viscus, and Wilks showed the heart, with one cusp of the aortic valves split right across, with some fibrin forming on the torn edges. The picture is on record in the *Transactions of the Pathological Society of London*. I would suggest that similar lesions, in these latter days, might never reach a clinician. This is a reasonable deduction, if one looks for contusion of the myocardium in fatal accidents of traffic and industry. Four or five years' search in the coroner's mortuary has produced quite a number; of which, on only one or two occasions, would the contusion seem to be the lesion causing death. The other contusions could be dismissed as secondary; but they are not without interest, when one meets a clinical case suggesting myocardial injury.

To return to the idea of questioning the relatives to collect all the possible clinical evidence. Is it not time that we tried to learn a little more about sudden unexpected death in disease of the coronary arteries?

Sir Thomas Lewis says: "Angina pectoris and myocardial failure never can have equivalents in the terms of structure." To lay stress on the functional capacity of the heart is the important thing in clinical medicine. The clinician has a fairly clear understanding of a slowly progressive heart failure, with or without passive congestion; but sudden, unexpected death is quite different. Ought we to name this "heart stoppage"? I have read, in a medico-legal book, of heart failure described as a slow deterioration of the heart muscle, until one day it reaches a stage when the organ cannot carry the load, and death supervenes. It sounds very plausible; but it does not fit the clinical story. The whole point about so many of these inquest deaths is that we have no evidence that the functional capacity of the heart was deteriorating; there was little or no heart failure until there was heart stoppage. Something went wrong at the centre—probably, of course, a thrombosis in the anterior coronary artery, but not on all occasions.

Thirty-five years ago, an express train engine-driver, drove his train into Derby Station, was walking across the platform when he fell dead. At the autopsy his anterior coronary artery was so rigid that I could break it like the stem of a clay pipe. The appearance would have passed for the description of John Hunter's own heart. The next week I carried out a post-mortem examination on another man, who died suddenly in the street. There was just a little narrowing of the orifices of both coronary arteries. It was a wonder the first had lived so long, and rather a mystery why the second should die so soon. We did not know the importance of coronary thrombosis in those days. I am writing of a time long ago, when a witness had to kiss the Book; and some coroners watched to see that a medical witness did not kiss his own thumb instead. In any case it is ordinary experience to accept disease of the coronary arteries, either gross or trifling, as an explanation. Gull said: "Fools and savages explain; wise men investigate." With the opportunities one could have taken, I think it has been foolish not to have investigated sudden heart stoppage. Are the dangerous years from sixty to sixty-five? Is there a change of life in men? In what way, if at all, does effort come in? Is anxiety more important? What causes the arterial disease and when present, however slight, is life just a matter of chance?

In 1732 Nicholas Robinson published in London, "A Discourse upon the Nature and Cause of Sudden Deaths." I wonder what he wrote and what we have learned since?

The pathologist tells us that a clot is more common in the anterior coronary artery, but the electrocardiograph gives no such evidence. It is more serious in the anterior artery; the prognosis is more unfavourable. There must be something for the clinician to study, about the lives of those whom he never saw before their fatal termination. Lauder Brunton associated sudden death with tobacco-smoking. It may be so; although one is inclined to deduce from this that he did not smoke himself. I sometimes wonder if coronary thrombosis is commoner in heavy cigarette smokers; perhaps it is a fair deduction that I only smoke a pipe. There are a hundred questions to ask. It may be impossible to solve the problem. I was rather intrigued the other day to read in a daily newspaper, that a certain rural district council had asked their medical officer of health to consider this problem—the headline ran "Cardiac Deaths Alarm Council." If I told one of my good friends, who is a medical officer of health, that it

was rather a quaint idea to bring this sort of thing to him. Where should I be if he asked what the clinicians of my generations had done in the way of investigation ?

With so much medico-legal work in these days, however, it is well to remember that there is almost a conflict between satisfying the law and satisfying science. When a man has sworn on many occasions to give the whole truth, he may tend to think he has found it. The words of Sir Thomas Browne, when he uses an anatomical analogy for a general proposition, are worth remembering in the mortuary. "Some have digged deep, yet glanced by the Royal Vein; and a Man may come unto the Pericardium but not the Heart of Truth."

The doctor in fiction was known to us many years ago. Most of them have held an honourable position in the mind of the public; and a few have been approved of by the profession. With the progress of time it is of interest that we now meet the pathologist in the detective story. Here is an advertisement of a so-called "thriller" in 1944 :—"Suppose you were told by a Home Office pathologist that the girl to whom you are engaged is not twenty-eight, but forty-one; that she has had three husbands, each of whom committed suicide by the same means; and that Scotland Yard considers the lady worth watching. Suppose, next morning, the pathologist were found dead. What would you do ?"

It is a nice point for decision. I suppose the first thought would be of the old maxim that when a new book comes out one should read an old one. But we might reflect on some of the unnecessarily sensational medical evidence given in courts of law. Evidence which would not always stand up to critical examination in a scientific medical society.

The medico-legal work in relation to accidents requires watching, that finality is not accepted, because something is settled in law. Books written on trauma contain some valuable clinical stories and other reliable medical evidence. Recently a reviewer recommended one to the "young traumatist"—a rather startling expression, which at first I thought had reference to child psychology. It so happens, when I read the book, that I was working at a particular problem, in which I found much evidence of assistance, in the form of clinical stories. But when the medical evidence is concluded and we get a record of "the finding of the Court," science is shaken. The law wishes for finality and precedent, but science must progress. In 1872 Gull, in his presidential address to the Clinical Society, said he "was old enough to know that itch was once considered to be a constitutional disease." Presumably he would have given such evidence on oath, which might have been a "finding of the court."

The clinician must build on the foundations of morbid anatomy. Gull, discussing rival bodies giving a medical qualification, said : "The road to medical knowledge is through the Hunterian Museum and not through an apothecary's shop." So it was before the days of Pasteur, and is to-day; but there is some change. Who could see in 1870, or thereabouts, that we should learn that many of our worst diseases were due to some infecting organism, for which in the nineteen-forties we might have a remedy from the chemist's shop.

The vaccine therapists told us that the physician "as we know him will die out"; it appeared to them that active immunisation with a vaccine would be the cure for all our ills. The story of how Sir William Osler turned this aside, in an after-dinner speech, with some well-chosen words to illustrate the value of a diagnosis, is too well known to tell. But he made the point that an abdominal tumour may sometimes be dispersed by means of a catheter.

The work of the physician must be founded on morbid anatomy, although bacteriology, hæmatology, biochemistry and other branches have widened the scope of pathology. The detailed investigation of morbid anatomy by the pathologist is increasing knowledge, but there are problems for elucidation that require clinical experience. It is a good thing for the clinician to hear the last word from the pathologist. It may appear so simple after death. In our own hospital we have a session once a week, at which all the morbid anatomy is laid out for discussion.

It seems like the end of the story. If the diagnosis has been correct the clinician is happy; but not for ever afterwards. He may feel that there ought to be a sequel. Which, possibly, in contrast to most sequels, might be more interesting than the original tale. And, furthermore, the new idea must spring from clinical sources.

Poem for Christmas, 1944

WHEN shades of Christmas
Fall upon this sight,
Barren though it be
And stripped of its investing
Tenements by might
Of savage war,
The spirits of the past
Break out to clear
The mists of presentness,
And fill a joyful cup
Of old tradition.

When Thomas Guy awakes
On Christmas morn
From out his year-long sleep
And, stretching creaky fingers to the sky,
Essays to step him down
From off his stately pedestal,
Some late, intoxicated soul
May start, to hear
Infuriate clangour of his bronzéd fist,
The muffled shout of him incarcerate,
'Neath thick brick wall:
"Unloose me here!"

Whilst on their beat,
In slow and measured tread,
The famous men of old meet
And pass, silent as the dead,
To pay eternal homage
To their founder.

But, as they gather round
His hallowed place
And kneel before his column
On the ground,
Their faces cloud:
"Who dared confine our master thus;
Who dared to quell
His kindly voice with masonry?"
And, as they 'gin to speak,
Consult in angered tone,
Young Keats sweeps in,
Another older, stately
Bearded man upon his arm.

In accent sweet
This stranger speaks,
Knowing full well
His anxious multitude:
"Raise, then, *thy*
Christmas Carol to the sky
As I raised mine;
Proclaim a worthy praise
To Thomas Guy!"

Then sing the worshippers,
Devout and loud,
Whilst all the city shakes.
Black clouds do lower overhead
And the earth quakes;
Then rises Addison,
His head still bowed,
Who, with a strong cane,
Smites the tomb
Of brick and mortar;
Both fall cleft in twain,
Releasing the time-honoured prisoner.
Smiling, then he lauds them all,
Shakes off the dust
And steps down from his pedestal.

Then Guy and Astley-Cooper,
Addison and Bright,
Nodding in thoughtful silence
At each new sight,
Followed by the multitude,
Pace slowly through the Colonnade
And fade into a blaze of light.

J. G. P. H.

Obituary

FREDERICK NEWLAND-PEDLEY, F.R.C.S., L.D.S. (Eng.).

GUY'S have lost their senior consulting dental surgeon and the Founder of the Dental School by the death of Newland-Pedley in May of this year, in Italy, where he had been residing for a number of years. He was born in 1855, the son of Percival Robert Pedley, a dentist who practised at 12, George Street, Hanover Square. In 1872 he was apprenticed to his father, but shortly afterwards his father went with his family to Australia on account of his health.

He returned to this country and entered Guy's as a medical student in May, 1877. At that time Salter was Dental Surgeon to Guy's and Moon was Assistant, and it was on the advice of Moon that he entered the Dental Hospital in Leicester Square, from where he obtained his diploma in dental surgery in 1880. In the following year he took the M.R.C.S., and the fellowship in 1885. In this year he was appointed Assistant Dental Surgeon to Guy's and acted as assistant to Moon. During the time he was reading for the fellowship, he started practice in Finsbury Square, close to Moon, and also did a good deal of coaching for the dental diploma; he was always a good teacher and it was his proud boast that only two of his students were referred.

In 1887 he was appointed Dental Surgeon to the Hospital, and he now had the opportunity of extending the reforms, which he had already endeavoured to institute. This was in the main the substitution of conservative dentistry in place of wholesale extractions and foreshadowed the institution of a dental department where all forms of dental surgery could be performed.

As a start he was granted a special room with two chairs in which he ran an improved department at his own expense; Wynne Rouw, who was completing his medical course, assisted him. Requests for fillings from students, sisters and nurses, in addition to the increasing work for out-patients convinced him that there must be more help in the form of students, which could only be met by the institution of a dental school.

A holiday in Paris was devoted to the drafting of a scheme for such a purpose, which was brought before a staff meeting in May, 1888. The scheme went through the usual evolution—reference to committees, opposition from vested interests, opposition from some of the staff of the Hospital, letters and articles in the medical and dental journals. It is strange to read to-day that one of the arguments against the scheme was that there was no need for a new dental school.

Newland-Pedley was not a mere visionary; he had his scheme cut and dried, for his intention was an improvement in treatment for hospital patients and the education of future dentists. He was fortunate in the co-operation and support of Cooper Perry, who was already well known for his work in creating the College and, as Newland-Pedley said, "his unlimited powers of organisation carried him from one great work to another until it was truly said that he left his name written on every wall of Guy's," a room was erected and equipped with twelve wooden operating chairs. This formed the conservation department and was ready for use in October, 1889.

"N.-P.", as he was known to students, was lecturer on dental surgery, and it was his habit to reserve a short time at the end of the lecture for questions, not always appreciated, but from which a great deal could be learnt. He was a fine teacher and his advice and assistance was always available.

When the foundations of the Dental School were being laid, quantities of extracted teeth were mixed in the cement, knowing that after all they had been the real foundation of the School, and hoping that in time to come they might give antiquarians something to think about.

During the war in South Africa Newland-Pedley went out with Fripp as dental surgeon to the hospital of which he was in charge and was prepared to undertake any work that came his way, though he had long specialised on jaw injuries. His plea for dental appointments to the Army fell on deaf ears, though, towards the end of the campaign, a few were appointed. He wrote frequently on this subject and had his schemes, put forward in 1901, been implemented much of the suffering caused in the Great War would have been spared. In 1914 he went to Rouen and wrote in the Press of the need for Army dentists and proposed the formation of an Army Dental Corps. *The Lancet* criticised the demand for this formation as "injudicious," which drew

another letter from Newland-Pedley, who prophesied that when the history of the War came to be written, one of the features would be the prevalence of dental disorders. This, as far as one can ascertain, was his last appearance in dental literature—but how correct was his prophecy.

In 1904 he resigned the lectureship in dental surgery which he had held since the foundation of the School; and in 1907 he resigned his position on the Staff and was appointed Consulting Dental Surgeon to the Hospital.

On his retirement his colleagues and the students presented him with an illuminated address, together with a sum of money for the purpose of establishing a gold medal for practical dentistry bearing his name, as a permanent record of his valuable services to Guy's Hospital and Schools. The medal bears a portrait of the Founder of the School on the one side, and, on the reverse, the arms and motto of the Hospital. The first medal struck was presented to him.

Newland-Pedley was a shy and reserved man, except where the interests he had at heart were concerned, then he was capable of very forcefully championing their merits, and this he did very frequently in the medical and dental journals, and time has proved that much of what he strove for has come to pass. There can be no shadow of doubt that his name will be remembered and revered by Guy's dental men for all time.

F. J. P.

Old Christmases

MY mother was the secretary of the Hampstead branch of the Ladies' Association which was allotted to Philip Ward, and she used to visit it. That was why at Christmas-time, 1902, I found myself helping with the decorations there. Philip was the large medical ward on the south side of the staircase on the first floor, and Sister Philip was the apotheosis of everything that was austere in the nursing profession. She epitomised all that has ever been said or depicted of this type, whether in fun, in sarcasm or in fact. She was very tall, very skinny, with an immobile countenance, and a walk that indicated flat feet, though no one ever confirmed this, as her skirt fell well below her ankles. She wore a low turn-down collar tied with something that looked like a shoe-lace, and her hair was brushed hard back and fixed as a tight bun below her occiput. Some two years later a perky little pro. sent to her ward for an hour or so, was given the task of "carbolising" macintoshes, which meant scrubbing them with lysol. Being pleased with her work, she ceased for a moment as Sister came along and, putting her head on one side, said: "That looks nice, doesn't it, Sister?" And Sister, without ceasing her police-like tread, pointed at the macintosh and said: "Scrub it!" The ward still had a text over every bed and the amount of work we put into the decorating was enormous, with great festoons of greenery coming to a point above every frame. You could not prepare ahead with laurel, fir and holly as you can with paper, and everyone was raked into the task, including convalescent patients. There was a tradition that a few years previously one of these had fallen dead from the top of a ladder while fixing the festoon to a nail near the ceiling, having ruptured an unsuspected aneurism. But it was next year that I remember better, by which time Philip was closed for renovation, the texts and the name had disappeared for ever and, for a while, the male ward was on the other side of the staircase, presided over by the same Sister. She did not approve of concerts, but, liked my mother to bring a few people who would give them "a little good music." Now my mother and father and an aunt belonged to a madrigal society, and every Tuesday in the winter they used to go round to a friend's house and sing Palestrina masses in parts unaccompanied by any instrument, but started by a whistle to give them the note. It was this madrigal society that went to give the good music. I tried hard not to turn up, but my mother ordered me to do so. I was still not in the wards, being student demonstrator of anatomy; but I knew a good many that were in them who had preceded me there from the dissecting-room or whom I had got to know in the football team. It is very likely that with the great love of music shown by students to-day they would appreciate unaccompanied Palestrina masses alternating with 'cello solos, but in those days we were not educated up to this. It is almost impossible to realise the chasm between then and now in the matter of music. We were complete "rough-necks." "Daisy, Daisy" was as far as most of us went; and, if we rose above Gilbert and Sullivan, the Soldier's March in

"Fraust," as we opprobriously called it, was our peak. And there was I trying to hide myself at the back of the ward as each student came in and burst into loud imprecations of Sister and the "awful old frumps" whom she had gathered together; and then someone would dig him in the ribs, nod his head sideways at me and whisper loudly: "It's his mother." It was the leader of the madrigals—the one who blew the whistle—that gave the 'cello solos. He was a dear old fellow—as are his two sons now, and may they forgive me when they read this—but he had a long beard which fell down over the upper part of the strings of his 'cello, which he played with his eyes shut, so that everyone thought he was sound asleep. It was nine years before the production of Shaw's "Pygmalion," in which Mrs. Patrick Campbell introduced "the word" into Society, but its omission from the imprecations of my fellow-students did not make them the less powerful.

The next year—1904—all was changed. I had got into the wards in the previous April, and so was Assistant Surgeon's Dresser to Sir Alfred Fripp, which meant I was working in Pat. and Sam., to which I attached myself sedulously. There were several reasons for this. One was that Naaman and Dorcas, in which were his other beds, were the preserve of the Jacobson firm, to which he was Assistant Surgeon. Another was the nursing staff. It is only since the War that I have learnt that the habit of men and nurses getting engaged, and subsequently married, is almost special to Guy's among all the teaching schools. Long may it last! But I have observed that now, as then, in spite of the unbelievable difference in the social relations between the two groups, Guy's men tend to go through two stages in their relations to the nurses. First, they roam among the many, then concentrate upon the one. In my case the first stage was very short, for the junior pro. in the first ward into which I ever went laid me by the heels. But she was on night-duty and as I did not live up I had no chance of seeing her. I was therefore free to encourage a calf-like admiration for the two head nurses in Pat. and Sam., whom I then looked upon as quite elderly. This is borne out by the fact that we called the one on night "Auntie." It was the handsome one on day to whom I attached myself as odd job boy for the ten days over Christmas. But, in spite of the head nurse, I believe it was the wards themselves that most drew me to them. They were quite incompatible with any modern ideas of hospital construction or ward administration. And yet I maintain they were the best wards I have ever worked in. They were so homely, so matey or chummy. The sloping roofs with the beams in them got in the way of dressings; but they gave an impression of friendliness, above all others, that had an influence towards recovery unimagined by young materialists.

I sang a song that year—the only one I ever did and the only ward I ever did it in. It was called "My heart's good but my feet won't let me—feet won't let me go." It was sung at an old lady who was a patient of mine and who was inclined to give way to a cellulitis of the left lower limb that had extended from the foot to the groin with thirty incisions, each of which had in it a little nick of gauze that in those days one called a "drain." We lugged her out of bed for half-an-hour on Christmas Day and pushed some turkey into her mouth. Then the niggers came and she roared with laughter. After that we put her back to bed. She slept sound that night and never turned back. She is not the only patient I have known whose life was saved by the niggers.

T. B. L.

Impressions from India

DEAR DOC,—If you join the R.A.M.C. when you are called up, and are so unfortunate as to be sent on a draft to India as soon as you are commissioned, you may be grateful for the tips I can give you. My remarks apply mainly to Regimental Medical Officers attached to units, but as far as text-books are concerned, they apply equally to those on the staffs of hospitals, field ambulances, etc.

Excuse me calling you "Doc," but in the Army you will be "Doc" to all officers, and you will get used to it, however much you may dislike the term at first. To British troops you will be known as the "M.O," and to Indian troops as the "Doctor Sahib."

While you are at the R.A.M.C. depôt, make the most of your courses, particularly those on hygiene and sanitation, and on water duties. Make sure that you get copies of "The Manual of Hygiene and Sanitation" (1934). There may be a revised edition of this manual now. Also a little book called "Water Supplies in the Field" is invaluable. These books are issued on the courses usually. Your tropical medicine

course is worth every hour spent on it, and make plenty of notes, especially on mosquito control. It is a cram course, and if you are lucky enough to be lectured to by Manson-Bahr you will enjoy it. I have been unable to find any concise book on mosquito control. That is why I advise you to make good notes on the subject.

Now about text-books. The most important point about text-books is to bring all you need with you. Don't rely on being able to get any when you get here. Unless you are stationed in Bombay, Delhi or Calcutta, your chances of getting a book you want are remote. From your own experience you know you can get any book of your choice in London or from any of the larger provincial cities. Out here it is very different. I was first posted to Bangalore, a town the size of Cambridge or Tunbridge Wells, and the best bookshop in the town had to write to Bombay, 800 miles away, for two books I asked for. They could not get them. I advise you to bring a text-book of medicine, a synopsis of surgery, and Manson-Bahr's " Text-book of Tropical Medicine " as foundation stones. You should get issued to you at the School of Tropical Medicine an Army Memorandum of Diseases of Tropical and Sub-tropical Climates. This is a very concise memorandum which you can take anywhere into the jungle, whereas under those circumstances you would probably leave your Manson-Bahr at the base. A book on skin diseases and another on eyes would be valuable. Your own personal choice of the actual author of the text-book, selected with the advice of your Registrar, will probably suit you better than my choice. Besides, a large number of good text-books have been published since I was in London last which I have not had the chance to see. Unless you propose to become a surgical specialist, I should advise you not to bring a large surgical text-book, particularly one in two or three volumes. As an R.M.O. you will see very little surgery, and your job in the forward area, except when you are isolated, is really only first-aid, and rapid evacuation. Even in a C.C.S. or an advanced surgical unit, a synopsis of surgery should be sufficient as a book of reference on which to hang your surgical knowledge. When you pack up your kit to come abroad, you are allowed, as a doctor, 28 lb. extra weight for text-books and instruments. Make the most of this and don't worry if all you want comes to 40lb. I was conscientious about weight, and actually brought extra clothes instead of books which I hoped to get here. Now I am suffering for it.

Now about instruments. You don't need many as an R.M.O. and, in a hospital, none at all. They will provide all you want. As an R.M.O. I strongly advise you to bring a head mirror and a set of three aural specula. The largest can be used as a nasal speculum, if need be. The Army at home supplies every M.O. with an electric auroscope. Out here your nearest hospital may not even have one, but probably will have a Brunton auroscope. The R.M.O. is not issued with one. I have to take my men twelve miles by truck to the nearest hospital to examine an ear, and then the trouble may be only due to wax, which hardly seems worth the petrol expended on the journey. A strong thermometer case is worth having. The Army will provide the thermometer, but not always the case. A 2 c.c. syringe in an airtight case, ready sterilised, is a useful possession. To keep a syringe ready for use is not easy in a hot country where spirit evaporates very rapidly. Don't bring all your instruments, including an electric ophthalmoscope. The Army is a hard taskmaster and won't replace any damaged equipment except its own. If you break the bulb of your own ophthalmoscope (and the spare one, too) you've " had it." You won't be able to get spare parts anywhere except possibly from Bombay or Delhi, and you will be lucky if you can find out the address of a surgical instrument company in either city. Another consideration with regard to bringing expensive surgical instruments abroad is the possibility of your ship being sunk on the way, when you will lose everything. If you survive, you will probably want another instrument which in the post-war years will probably be very expensive, and perhaps difficult to get. This factor does not apply to text-books so much, as they are more easily obtainable, and you will at least have the satisfaction of buying the latest editions when you restock your medical bookshelf. Still, it is up to you. You can take the risk if you think it worth your while, but purely from the point of view of being unable to get spare parts out here, I should advise you not to.

The next subject I would like to talk about is snakes. You may or may not get a lecture on them either at the depôt or on your course of tropical medicine. Manson Bahr's text-book of tropical medicine has a list of poisonous and non-poisonous snakes. The best concise list I know is in " Field Service Hygiene Notes (India)." This booklet, published in India, is obtainable from most area and command headquarters and is full of useful information. I advise you to ask your A.D.M.S. or O.C. Hospital for a copy as soon as you arrive. From what some people say you might expect to see

poisonous snakes every day. In fact, you don't; you need not walk in deadly fear of them. They won't attack you unless you attack them or accidentally tread on them. Night-time is the dangerous time. So bring a good torch with you. I have not see one at night yet.

When you arrive in India you will be posted to a hospital—that is, if you are not attached as R.M.O. to a unit and come out with it. You will stay at the hospital for about a month to get acclimatised and to see some tropical medicine. You may stay on there as a general duty officer, and, if you are a specialist, you will get a job in your own line. You may go on a course and be posted to a field ambulance later or you may go to a unit as an R.M.O. As an R.M.O. you will find that most of your time is taken up with hygiene and sanitation, water-duties and anti-mosquito control. Things won't plan out quite so easily as you may have hoped when you did those courses at home. Material and labour for constructing sanitary appliances are not easy to get. You must remember, also, that the standard of sanitation of the civilian contractors who construct your sanitary appliances is far lower than ours in England. I need only say, I think, to illustrate this that a bath with h. and c. and a water-closet are practically unknown in India except in the largest public buildings in the biggest cities. Don't be surprised, therefore, if your ideals of sanitation in the field are not attained even when you give the best advice. They may follow a hygienic design, but the coolie who does the job will make a mess of it through his own ignorance of hygiene. You will get what you want in the end, I hope; but not without an exasperating struggle.

Well, Doc, I hope you benefit from my experience, and if you come this way that you will pass your tips on to others. None of this can be learnt from any book, and you will be lucky if you meet anyone who has been out here in war-time before you start. Personally I did not know I was coming to India until I was two thousand miles from England. Perhaps you will know sooner.

Yours sincerely,

R. G. TICEHURST,
Capt., R.A.M.C.

Reviews

Cæsarean Section. The History and Development of the Operation from Earliest Times. By J. H. YOUNG, M.B., Ch.B., D.T.M. & H. (Edin.). Demy 8vo. 254 pp. Published by Messrs. H. K. Lewis & Co., Ltd. *Price* 16*s. net.*

DR. YOUNG'S thesis for the degree of M.D. (Edin.) must be one of the best theses ever written. The author has collected most of the known facts about the Cæsarean operation. The origin of the name, the controversies which raged between the exponents of the operation and the craniotomists in the seventeenth century, the gradual evolution of the technique of the modern operation, the indications for its performance; all these aspects are fully considered. A full bibliography enhances the value of this research into forgotten literature.

It is not necessary nowadays to emphasise the merits of the Cæsarean operation. It is a spectacular procedure and it can be claimed that it is unique in surgery in that it may be the means of saving the lives of two individuals. Rather it is necessary to stress its risks and its limitations, for it is dangerously easy to perform. Although the operation is mentioned by the earliest medical writers its performance was justified only in the most desperate cases before Lister's discoveries enlarged the field of abdominal surgery. It was not until 1796 that the first case is recorded in England, with survival of both mother and baby, and writers in 1865 were able to give details of only seventy-seven cases with a mortality of 86 per cent. of the mothers. By comparison it may be mentioned that in the ten years 1928–1937 there were 436 Cæsarean sections in the Guy's Hospital Maternity Department with a mortality of 2.5 per cent.

In the middle of the last century Porro, of the University of Pavia, revolutionised the operation by introducing the principle of Cæsarean hysterectomy which must have saved the lives of hundreds of parturient women. Guy's men will be interested to be reminded that James Blundell, Obstetric Physician to Guy's Hospital, paved the way to this important discovery by his experiments on pregnant rabbits. He it was who, attacked by the antivivisectionists of his day, in 1830, made the classical rejoinder, "Which will you have—your women or your cats?" No obstetric surgeon can fail to derive instruction from perusal of this work; he will realise how much the perfection of the modern operation owes to his predecessors. Even the doctor not engaged in obstetric practice will find this book well worth reading. A. J. M.

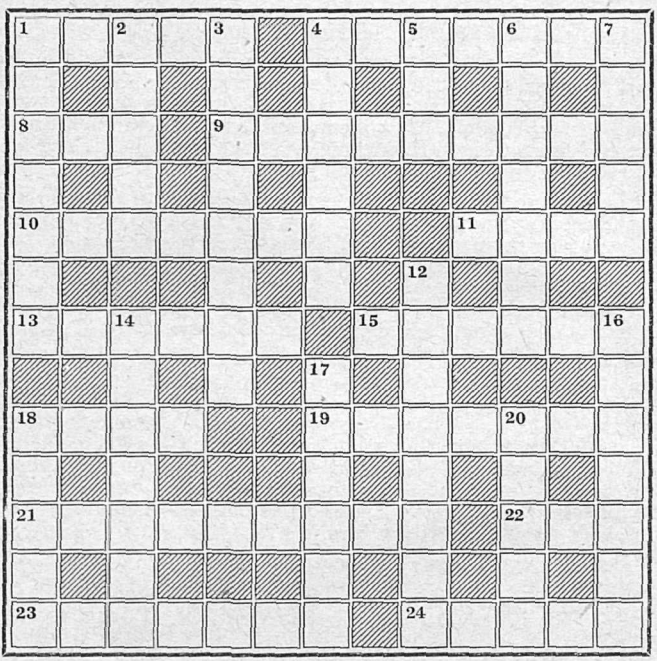
Crossword

A First Prize of £1 will be given for the first correct result opened by the Editor on the closing date. A Second Prize of 10*s.* will be awarded for the next correct solution.

Entries should be sent in before Saturday, January 6th, 1945.

The name of the prize-winners, together with the solution of the Crossword, will be published in the issue of January 20th.

Please mark entries "Crossword." The decision of the Editor must be taken as final.



DOWN.

1. Unreliable measure of quantity (7).
2. A step for the soldier going into battle (5).
3. Pickwickian reference to a member of a noble profession (8).
4. Legal term—a little more than a put up job (6).
5 (*together with* 12, i.e. *one word*). Sentimental revivalist. (11).
6. Cover a capsized friend (7).
7. Essentially sensational (5).
14. Is the card being repaired ? It isn't safe yet (7).
16. The favour is set well in the memory (7).
17. Spirit out of Biscay ? (6).
18. Not a permanent figure at the table (5)
20. Progeny (5).

ACROSS.

1. Dislikes as the anagram (5).
4. Game for a sapper (7).
8. —and one for the lazy fellow (3).
9. A Cockney greeting in full (9).
10. Adorn (7).
11. Song for a merry Elizabethan (4).
13. Followed the horse into battle (6).
15. Borough belle in August (6).
18. Not a peer of the Realm (4).
19. Trees, which might prove a sticky problem (7).
21. Not a member of the Odd Fellows (9).
22. Don't stand for this sort of order (3).
23. "To die, to sleep :
    To sleep, perchance . . . . . (2, 5).—*Hamlet.*
24. A female of the avian species (5).

{G.F.V.
J.E.B.

Correspondence

BRITISH DENTAL STUDENTS' ASSOCIATION AND THE INTERIM REPORT OF THE INTER-DEPARTMENTAL COMMITTEE ON DENTISTRY.

To the Editor of the GAZETTE.

SIR,—The Interim Report of the Inter-Departmental Committee on Dentistry cost £1,400 4*s*. 10*d*. to prepare. This report may be had from the Stationery Office for 6*d*. In our last letter published in your columns (Decemner 9th, 1944), a brief plea was made that each dental student should possess a copy of this report. Besides this, a notice has been exhibited on the board in the entrance to the Dental School to the same effect for some considerable time.

The degree to which lack of interest in this serious matter can be noted appals us. We do believe, however, that when the seriousness and implications of a comprehensive health scheme are realised the wheels of progress will again begin to turn. We, the dental students of this country, are unhampered by cynicism ; nor are we bound to accept old worn-out practices to the detriment of our virile enthusiasm for our chosen profession.

It is up to each and every one of us to probe deeply into the politics with which our dental profession is bound together. Not only must we individually investigate the various dental organisations (British Dental Associations, Public Dental Service Association and the Incorporated Dentists' Society), the Dental Board of the United Kingdom, too, must have some of our attention. Besides the facts that we should all possess relating to our chaotic position amid all these active bodies, we should begin side by side to formulate and discuss plans for our future.

Revolution in the dental world is probably undesirable, and the outcome of revolution is of doubtful value. One necessity is certain, and that is " unity of purpose." Some months ago, at a meeting of the Dental Society you elected your two representatives to the B.D.S.A. We, your two representatives, were both very keen to represent the dental students at Guy's, but in this matter we need much help. Firstly, we need to know your views on all matters dental, if we are to be true to the position you have entrusted to us. And, secondly, not only must we, your representatives, understand your views, but your fellow-students must also become aware what you are thinking about current dental politics.

It is intended, during the next few weeks, to publish the views of students on the post-war organisation of the dental profession, with special reference to the formation of a national dental scheme.

There are just over two hundred students studying with a view to forceps and amalgam, and we shall not be overwhelmed if each of you write to us in tears, after investigating the profession into which you have enlisted, unwittingly.

Yours, etc.,

P. SHINGLER,

DAVID BAKER,

Guy's Representatives, B.D.S.A.

POST-GRADUATE COURSES.

To the Editor of the GAZETTE.

SIR,—I wish to put forward a strong plea that Guy's Hospital should provide post-graduate courses after the War.

There must be many Guy's men, like myself, who have held appointments throughout the War which have carried the minimum amount of clinical work. As a result, our brains have become rusty through lack of stimulation and our memory of medicine faded.

In fact, I feel that I shall emerge from this War with an intimate knowledge of cyphering, censoring, triplicating, and of the running of wine and mess accounts, but I shall certainly not emerge as good a physician as when I left my practice four and a half years ago.

In the old days Guy's had a reputation for teaching which was second to none, and it would be sad if this was not upheld in the post-graduate field. I am sure that

the majority of Guy's men would prefer to return to their old Hospital for the post-graduate tuition, which, I think, is so essential if the pre-war standard of medicine is to be regained on returning to civilian life. It would be a thousand pities if Guy's Hospital did not make some effort to " rehabilitate " (to use the modern term) any of her men who have suffered from a lack of clinical experience and who feel that their efficiency has been lowered as a direct result of this war.

The syllabus of the post-graduate course should include practical instruction and clinical teaching in all the latest advances and methods developed recently; and most of us, I am certain, will need quite a lengthy refresher course in midwifery and gynæcology, especially. The length of the course would have to be measured in months rather than weeks if it is to be of lasting benefit.

The difficulties of providing such a course must be great, but, I hope, not insuperable, for if Guy's Hospital were to start post-graduate teaching the Hospital itself, as well as those attending, would derive much benefit.

Yours, etc.,
DAVID W. GEIDT.

Abbotsleigh, Exmouth, Devon.

PROPOSED NEW GUY'S HOSPITAL.

To the Editor of the GAZETTE.

SIR,—Having seen the models of the proposed new building of Guy's and read Mr. Hall's description in the *Gazette*, it has occurred to me, in view of the absence of comment, that a plea ought to be made against tacit acceptance of the style implied.

Mr. Hall made it clear that the models were not a representation of the proposed architectural style, but by clothing them in a facade, which, for want of a better term, could be labelled Georgian, he has thereby made it more difficult to break away from an outworn tradition. Goodness knows that will be hard enough in any case and, in all probability, he has judged it wise at this state not to offend public opinion which in this country, as compared with America and the Continent, has been appallingly backward.

If ever buildings require to be " functional," hospital buildings are such. Guy's is not a collection of individual homes under one roof, and therefore cannot be expected to look like Dolphin Square, as suggested by the models. On the contrary, Guy's is a humanistic factory, and cannot afford to look like anything but what it is. This is not a matter of taste, which notoriously is not debatable, but of efficiency, which is a matter of economy of means to obtain service and amenity. The point can be exemplified with reference to the speciality of dentistry.

Dental chairs must be well lighted and, under the usual methods of building, only one row of chairs can be placed on a floor where there is no top lighting, because the external walls are supporting walls and are, therefore, partly made of opaque substances. If the skeleton of the building were inside, and the external walls hung from cantilevers, then the whole wall could be of glass, and two or even three rows of chairs could be used on intermediate floors. Apart from the economy of building and land costs arising out of a free plan and elimination of lighting wells and courtyards, there would be a great saving of maintenance and teaching costs. In case it is thought that these suggestions are armchair visions reference should be made to the work of Frank Lloyd Wright, Eric Mendelson and others. From the point of view of equipment and building our Dental School has not been in the van. I propose that it should lead in these as well as in teaching.

In this wet autumn an illustration of the need for functionalism, which also serves as a definition of the term, is provided by the picturesque new pavement in the Park. Many of us would give a good deal to have old worn paving in our gardens where beauty can come before efficiency, but for daily use we expect to be spared the unreasonable amount of paddling we now have to do.

Returning to my own speciality, there is an essential point of planning, which is, that dental chairs must not face the sun later than 10 a.m., otherwise blinds and artificial lights are required. I am not convinced that this point has been tentatively satisfied.

Yours, etc.,
ALLAN THOMPSON.

Dental Department, Guy's Hospital.

Sport and Hospital Information, etc.

Rugby

GUY'S *v.* OLD BLUES.

(*At Honor Oak Park, Saturday, November 25th.*)

To be beaten by Old Blues war-time XV by a goal and two tries to a penalty goal and a try sounds very bad for Guy's Rugger, especially as D. J. Marriott, the Blues star wing three-quarter, was absent and other changes were made in the advertised side.

Once again our back division failed in their efforts to make headway by inaccurate passing and poor backing up. R. D. Willcock gave a fairly good service from the scrum, but invariably after the ball left his hands, the movements were slow, the passing erratic, and whole line lacked the necessary finesse to go through the gaps which were obviously there.

The Old Blues made good use of the long pass, alternated by punts ahead, or across the field, which frequently carried them into an attacking position. They led at half-time with a try by D. J. Smith, a fast and elusive winger, following a bout of accurate handling all along their three-quarter line.

Soon after the interval Guy's drew level when L. Le Clus kicked a penalty goal, and then took the lead with a neat try by W. Selley, who gathered the ball from a kick ahead by H. Richards, to cross in the corner. The Old Blues were kept on the defensive for a while, until A. H. Ross-Goobey intercepted a pass, to send D. J. Smith racing away from half-way, which ended under the posts for G. A. Gilmour to convert.

Following a scrum near our line, the Blues three-quarters sent the ball from right to left in lightning fashion for R. A. Jones to complete the scoring with an unconverted try.

GUY'S *v.* COVENTRY.

(*At Coventry, Saturday, December 2nd*, 1944.)

Coventry won this game by 2 goals, 1 penalty goal and 4 tries (25 points) to nil.

At the last moment R. D. Willcock was unable to travel, which brought in K. G. B. Pritchard at scrum half to I. Davies, and it was at half that Coventry had an overwhelming superiority, with Stock and Preece in grand form. Our forwards were more than a match for the powerful Coventry pack, even shoving them in the set scrums, and with A. B. Lee in his best hooking form, our backs should have made more use of their chances. Whenever possible, our forwards successfully made it a forward game and carried play dangerously near the Coventry line. Credit must be given to R. G. L. Brittain, A. Batty-Shaw, I. H. Hilliam and, finally, A. B. Lee, who played in the form that took him into the Barbarians' XV.

Never at any time did the game become one-sided, yet tries came from Coventry at frequent intervals by means of accurate passing, the individual play of Stock, Preece and Harris, and grand backing up by the brothers Wheatley, the brothers Walker and Wright.

Coventry led at the interval by a penalty goal kicked by Wright, and tries by Wright, Harris and Greasley. The Hospital played up well in the second half and gave Coventry some anxious moments, but their undoubted skill enabled Preece to cross our line twice, and Sidwell once, two of the tries being converted by Wright.

A few old Guy's men were at the match including S. P. Meacock, Hon. Secretary, during our President's captaincy, and Dr. Fitzgerald.

GUY'S *v.* ROSSLYN PARK.

(*At Honor Oak Park, Saturday, December 9th.*)

Guy's tried hard to turn the tide of adversity, but in the end they were beaten by Rosslyn Park by 2 penalty goals and 2 tries (12 points) to a dropped goal and a penalty goal (7 points).

The Park had rather a weak three-quarter line compared with their usual standard, but even so they were better than our own set of backs in developing their attacks. In addition, they had more of the ball from the set scrums, which gave their two halves a distinct advantage, but our three-quarters deserve much credit for some fine defensive play.

Within five minutes of the start, Rosslyn Park were six points up. They made a storming assault, and, first, K. H. Chapman kicked a penalty goal, and then, almost immediately, Hollins crossed for an unconverted try. P. S. Carton-Kelly seemed to have the line at his mercy, but chose to pass and a good chance was lost. Before half-time K. H. Chapman kicked another penalty goal, and MacLachlan went over for an easy try, owing to our players stopping at the sound of the whistle on the Soccer pitch.

The second half started with two fine Guy's three-quarter movements, in which Richards and Selley were prominent, and then Hilliam and Carton-Kelly carried play to Park's "25," but Selley was unable to take the final pass. The Hospital were certainly having the best of this half and it was a fitting reward to their persistence when I. Davies dropped a neat goal, and L. Le Clus kicked a penalty goal.

A word of praise must be given to A. Batty-Shaw for his sound leadership of the pack, and also to P. S. Carton-Kelly and I. H. Hilliam for their fine play in the loose. L. Le Clus kicked and tackled splendidly, but he is obviously feeling the effects of our heavy grounds and his recent cartilage operation.

The writer spoke to an international of renown after the game, seeking his opinion of Guy's failure. His words were: "You have a grand pack of forwards; there is nothing wrong with your scrum-half and full-back; the three-quarters are better than they think they are, but they just fail to take advantage of their openings by passing at the wrong moment, keeping too close, and they are easily forced across field, leaving the wings covered."

Change of Address

A. C. Macrae-Gibson, Surg.-Lt., R.N.V.R., H.M.S. *L.S.T.* 410, c/o G.P.O., London.

H. C. Sturdy, M.D., 78, Nightingale Lane, S.W.12 (temporary).

Births

WINN.—On December 13th, 1944, at the Chesterfield Nursing Home, Clifton, to Gwen (née Close), wife of Captain H. W. J. Winn, R.A., of Balcombe Lodge, Haywards Heath—a son.

Deaths

SMITH.—On November 26th, 1944, at 231, Selhurst Road, South Norwood, Florence Emily (née Pullin), widow of Dr. W. H. M. Smith, age seventy-three years.

EDS { J.P.M.B. J.D.L.R.